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**UNITED STATES DISTRICT COURT
 NORTHERN DISTRICT OF CALIFORNIA
 SAN FRANCISCO DIVISION**

DAVID AND NATASHA WIT, on behalf of)
 themselves and all others similarly situated,)
 BRIAN MUIR, on his own behalf and)
 on behalf of all others similarly situated,)
 BRANDT PFEIFER, on behalf of the Estate of)
 his deceased wife, Lauralee Pfeifer, and all others)
 similarly situated, LORI FLANZRAICH,)
 on behalf of her daughter Casey Flanzraich and all)
 others similarly situated, and CECILIA)
 HOLDNAK, on behalf of herself, her daughter)
 Emily Holdnak, and all others similarly situated)

Plaintiffs,

v.

Case No. 3:14-CV-02346-JCS

**FIRST AMENDED
 CLASS ACTION COMPLAINT**

FIRST AMENDED CLASS ACTION COMPLAINT
 CASE NO. 3:14-CV-02346-JCS

1 UNITED BEHAVIORAL HEALTH)
2 (operating as OPTUMHEALTH BEHAVIORAL)
3 SOLUTIONS),)

4 Defendant.)
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INTRODUCTION

According to the National Institute of Mental Health, an estimated 26 percent of American adults suffer from some type of mental health condition each year, with six percent suffering from a severe mental health condition such as schizophrenia or major depression. About 11 percent of adolescents have a depressive disorder by age 18 and nearly three percent of 13-18 year olds suffer from severe eating disorders, which have the highest mortality rate of any mental illness. The seriousness of this problem is highlighted by the fact that suicide consistently ranks as the third leading cause of death for young people ages 15-24.

In addition, according to the Substance Abuse and Mental Health Services Administration (“SAMHSA”), an estimated nine percent of Americans twelve or older were classified with a substance use disorder in 2010. Between 2007 to 2010, about 38 percent of Americans twelve or older who needed substance abuse treatment did not receive treatment because they lacked insurance coverage, and could not afford the cost without coverage. The World Health Organization reports that mental health and substance use disorders are among the leading causes of disability in the United States, and the Centers for Disease Control and Prevention reports that 25 percent of all years of life lost to disability and premature mortality are a result of mental illness. When substance use disorders are inadequately treated, they can complicate care for co-occurring mental health disorders and medical conditions.

Despite these alarming statistics, Defendant United Behavioral Health (“UBH” or “Defendant”) is violating legal duties it owes to health insurance plan participants and beneficiaries by improperly restricting the scope of their insurance coverage for mental health and substance abuse-related residential treatment. These restrictions are inconsistent with the terms of the relevant insurance plans and generally accepted standards of mental healthcare.

Because they have been, and are likely to continue to be, harmed by UBH's misconduct, Plaintiffs David Wit, Natasha Wit, Brian Muir, Brandt Pfeifer, Lori Flanzraich, and Cecilia Holdnak bring this complaint against UBH on behalf of themselves and all others similarly situated. In support of their claims, Plaintiffs allege upon personal knowledge as to themselves and their own acts, and upon information and belief based upon, *inter alia*, the investigation made by and through their attorneys (including review of publicly available information concerning UBH's guidelines and correspondence sent by UBH to Plaintiffs) as to all other matters, as follows:

SUMMARY OF PLAINTIFFS' ALLEGATIONS

1. Plaintiffs David Wit, his daughter Natasha Wit, Brian Muir, Brandt Pfeifer, Lori Flanzraich, and Cecilia Holdnak are each insured by a health insurance plan that is sponsored by their (or, in the case of Natasha Wit, her father's) employer and governed by the Employee Retirement Income Security Act of 1974 ("ERISA") ("Plaintiffs' Plans").

2. Plaintiffs' Plans cover treatment for sickness, injury, mental illness and substance use disorders. All of the Plaintiffs' Plans provide that residential care is a covered benefit. All of the Plaintiffs' Plans explicitly classify residential treatment as a form of "intermediate" care, except Plaintiff Flanzraich's plan, which provides no classification at all.

3. Plaintiffs' Plans have delegated responsibility for adjudicating mental health and substance abuse-related claims to Defendant United Behavior Health ("UBH"). Pursuant to this delegation, UBH has developed "level of care" ("LOCs") and "coverage determination" guidelines ("CDGs"), which it provides to its claims representatives for use in adjudicating mental healthcare claims.

4. UBH's CDGs purport to identify, on a condition-by-condition basis, the benefits that are generally available pursuant to health plans insured and/or administered by UBH, the

1 “best practices” (as defined by generally accepted standards of care) that a mental healthcare
2 provider should follow when treating the condition, and “level of care” criteria (drawn from
3 UBH’s LOCs, discussed below). UBHs CDG’s instruct UBH reviewers to consult insureds’
4 particular plan terms before deciding whether particular benefits are covered.

5 5. UBH asserts that its LOCs are a set of “objective” and “evidence-based” criteria
6 used to standardize coverage determinations, promote evidence-based practices, and support
7 members recovery, resiliency, and wellbeing.” UBH’s LOCs set forth criteria that its claims
8 reviewers are supposed to apply to determine whether a particular level of mental healthcare is
9 both covered by the terms of the Plan and that such level of care is consistent with generally
10 accepted standards of care. Unlike UBH’s CDGs, however, UBH’s LOCs do not instruct UBH
11 reviewers to consult insureds’ particular plan terms before deciding whether a given benefit is
12 covered.
13

14 6. UBH has also compiled “Best Practice Guidelines” (“BPGs”) which are
15 “developed by nationally recognized organizations” such as the American Psychiatric
16 Association and American Academy of Child and Adolescent Psychiatry.
17

18 7. Plaintiffs’ Plans have no role in the creation and promulgation of any of these
19 guidelines, or in UBH’s decision to approve or deny any claim.
20

21 8. In light of its central role in the mental health and substance abuse-related claim
22 adjudication process, UBH is an ERISA fiduciary as defined by 29 U.S.C. Section 1104(a). As
23 such, it is legally required to discharge its duties “solely in the interests of the participants and
24 beneficiaries” and for the “exclusive purpose” of providing benefits to participants and their
25 beneficiaries” and paying reasonable expenses of administering the plan. It must do so with
26 reasonable “care, skill, prudence, and diligence” and in accordance with the terms of the plans it
27 administers, so long as such terms are consistent with ERISA. As a fiduciary, UBH owes a duty
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1 of loyalty to plan participants and beneficiaries. It must also refrain from any conduct that
2 violates state or federal law.

3 9. UBH suffers from an inherent conflict of interest in its role as mental health and
4 substance abuse claims administrator. Every claim denied by UBH saves money for UBH's
5 corporate affiliates and artificially increases the profit of its parent entity, UnitedHealth Group
6 Incorporated ("UHG"). The Wit, Pfeifer, and Flanzraich plans are "fully-insured," meaning that
7 health care benefits are paid by Defendant UBH's corporate affiliates, UnitedHealthcare
8 Insurance Company ("UHIC"), UnitedHealthcare Insurance Company of Illinois, Inc. ("UHIC-
9 IL"), and Oxford Insurance Company, Inc. ("Oxford"), respectively. Thus, every residential
10 treatment claim denied by UBH allows one of its affiliates to save money and artificially
11 increases the profit of UHG. The same is largely true with respect to Muir and Holdnak's plans,
12 even though they are "self-funded." Although these plans require that benefits be paid, in the
13 first instance, from the assets of Muir and Holdnak's group plan sponsors, most self-funded
14 plans have stop-loss provisions that obligate the insurer to pay benefits that exceed a certain
15 threshold. Thus, every claim UBH denies makes it less likely that such a stop-loss threshold will
16 be crossed and reduces the possible stop-loss liability of UBH's affiliates.

17 10. Against this backdrop, UBH has violated its fiduciary duties, as detailed herein.

18 11. Generally accepted standards of care are promulgated by the American Academy
19 of Child and Adolescent Psychiatry ("AACAP"), the American Association of Community
20 Psychiatrists ("AACP"), and the American Society for Addiction Medicine ("ASAM").
21 Generally speaking, these standards identify a host of criteria as being relevant to determining
22 whether residential treatment is the appropriate level of care for any particular patient, recognize
23 that residential treatment is an intermediate level of care between acute in-patient hospitalization
24 (which is generally required when the patient is a risk to themselves or others) and outpatient
25

1 treatment (which is generally appropriate when the patient is capable of monitoring their own
2 condition), and call for residential treatment when the patient's condition may be chronic in
3 nature (i.e., non-acute) and expected to last several months.

4 12. Although UBH asserts in its guidelines and in communications with insureds that
5 its LOCs and CDGs are consistent with generally accepted standards of care, and that it applies
6 generally accepted guidelines in making benefit determinations, neither is true. UBH has
7 promulgated LOCs and CDGs that are much more restrictive than the generally accepted
8 standards of care in the mental health community. Indeed, in the last 3 years, UBH has been
9 amending its LOCs to make them even more focused on the presence of acute symptoms (and
10 therefore more restrictive), despite the fact that generally accepted guidelines highlight chronic
11 considerations. As detailed herein, whereas UBH's guidelines restrict coverage for residential
12 treatment to "acute" situations that can be addressed quickly, such restrictions on residential
13 treatment are not found in any of the generally accepted standards of care, or for that matter, in
14 any of the Plaintiffs' Plans that UBH administers. Quite the opposite, generally accepted
15 standards recognize that residential treatment is particularly appropriate for the treatment of
16 chronic conditions and is often appropriate for an extended period of time, and Plaintiffs' Plans
17 contain none of the restrictions that are identified in UBH's guidelines and challenged herein.

18 13. Plaintiffs' Plans purport to exclude mental health and substance abuse coverage
19 when the treatment sought is inconsistent with generally accepted standards of care and UBH's
20 LOCs. (Plaintiff Flanzraich's plan covers such treatment so long as it is "consistent with
21 standards of good medical practice" and does not reference UBH's LOCs). Thus, in developing
22 its LOCs, UBH had a fiduciary duty to Plaintiffs (and to other members of plans administered
23 by UBH) to promulgate criteria that faithfully ensure that a particular level of care is both
24 covered by the terms of Plaintiffs' Plans and consistent with generally accepted standards of
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1 care. UBH breached this duty by supplanting generally accepted treatment standards in the
2 mental health field with standards that promote the self-serving, cost-cutting preferences of
3 UBH and its corporate affiliates. By adopting guidelines that are inconsistent with, and much
4 more restrictive than, those that are generally accepted in the medical community, UBH
5 breached its fiduciary duty to act solely in the interests of participants and beneficiaries for the
6 “exclusive purpose” of “providing benefits” with reasonable “care, skill, prudence, and
7 diligence” and in accordance with Plaintiffs’ Plans.

9 14. UBH further breaches its fiduciary duties by developing guidelines which ignore
10 explicit state laws mandating that claims administrators such as UBH utilize ASAM standards
11 when making medical necessity determinations. Yet, UBH developed and applied its LOCs
12 even though those LOCs are more restrictive than ASAM’s standards and those of similar
13 national medical specialty associations. Moreover, UBH’s LOCs neither state nor imply that
14 UBH’s claims representatives should consult applicable state law before applying those LOCs.

16 15. UBH has also violated its legal obligations under ERISA by denying residential
17 treatment claims that were covered by Plaintiffs’ Plans. These claims would have been covered
18 based on the terms of Plaintiffs’ Plans and generally accepted treatment standards, but were
19 denied as a result of UBH’s two-prong attack on benefit claimants. First, UBH promulgated
20 improperly restrictive benefit determination guidelines, which it then relied upon to deny
21 Plaintiffs’ claims. Second, UBH denied Plaintiffs’ claims even when they satisfied UBH’s
22 restrictive residential treatment guidelines, based on UBH’s systematic practice of: (a) applying
23 criteria found in its LOCs for acute inpatient treatment (such as whether the patient was a risk to
24 themselves or others, or whether the patient necessitated 24-hour care – as opposed to 24-hour
25 structure) to claims for residential treatment, even though UBH’s LOCs for residential treatment
26 did not list these criteria; (b) drawing factual conclusions about the medical condition of
27

1 Plaintiffs that were not supported by the evidence in UBH's possession, in order to conclude
 2 that the benefit claims fell outside the LOCs; and (c) citing additional benefit guidelines found
 3 nowhere in Plaintiffs' Plans, generally accepted standards of care, or in the UBH LOCs as a
 4 basis for denying coverage (for example, UBH denied Plaintiff Holdnak's claims based, in part,
 5 on an undisclosed internal length of stay "benchmark" that is not found in Plaintiff Holdnak's
 6 plan, generally accepted standards, or any published UBH guideline; similarly, UBH denied
 7 Plaintiff Muir and Holdnak's claims based, in part, on UBH's CDGs, despite the fact that those
 8 Plaintiffs' Plans make no mention of CDGs as a permissible basis for excluding coverage).

10 16. In order to remedy UBH's breach of fiduciary duty and other ERISA violations,
 11 Plaintiffs bring class claims against UBH under 29 U.S.C. § 1132(a)(1)(B), 1132(a)(3)(A) and
 12 1132(a)(3)(B). Through this action, Plaintiffs seek appropriate equitable and injunctive relief
 13 under ERISA to compel UBH to change its policies and practices so as to comply with its
 14 fiduciary obligations and to make benefit determinations which are consistent with generally
 15 accepted medical standards.

17 **DEFENDANT, JURISDICTION AND VENUE**

18 17. Defendant United Behavioral Health ("UBH"), operating under the brand name
 19 OptumHealth Behavioral Solutions, is a corporation organized under California law with its
 20 principal place of business located in San Francisco, California. UBH is responsible for drafting
 21 and promulgating the internal level of care and coverage determination guidelines referenced
 22 herein. It also adjudicates all mental healthcare and substance abuse claims for Plaintiffs' Plans.

24 18. UBH, UHIC, UHIC-IL, and Oxford are all, indirectly, wholly owned and
 25 controlled subsidiaries of UnitedHealth Group Incorporated ("UHG"). These companies do not
 26 operate independently and in their own interests, but solely serve to fulfill the goals and policies
 27 of UHG and generate revenue for UHG.

1 19. Subject matter jurisdiction exists pursuant to 28 U.S.C. § 1331.

2 20. Personal jurisdiction exists over UBH, and this District is the proper venue,
3 because UBH conducts significant operations in this District, regularly communicates with
4 insureds who reside in this District, and is headquartered in this District.

5
6 **UBH’S GUIDELINES APPLICABLE TO WIT AND HOLDNAK’S CLAIMS**
7 **CONTRASTED WITH GENERALLY ACCEPTED STANDARDS**

8 21. UBH has developed its own Level of Care (“LOC”) Guidelines that it uses to
9 determine whether any given level of mental health treatment is covered by the health insurance
10 plans that it is charged with administering. Among the LOC Guidelines authored by UBH are
11 those for “Acute Inpatient” and “Residential Treatment.”

12 22. UBH’s LOC Guidelines for Acute Inpatient treatment (2013) provide that “[a]n
13 acute inpatient unit is a secured and structured hospital-based service that provides 24-hour
14 nursing care and monitoring, assessment and diagnostic services, treatment, and specialty
15 medical consultation services with an urgency that is commensurate with the member’s current
16 clinical need.” Moreover, these guidelines expressly state that an acute inpatient level of care is
17 medically necessary when “the member is at imminent risk of serious harm to self or others,” as
18 demonstrated by suicidality, assaultiveness, psychosis, and grave disability.

19
20 23. UBH’s guidelines recognize that care in a residential treatment facility – as
21 opposed to an acute inpatient hospital – is appropriate for patients who do not require 24-hour
22 nursing care and monitoring and who are not an imminent risk of serious harm to themselves or
23 others. Indeed, mentally ill patients at “imminent danger to themselves/others” must, by
24 operation of laws throughout the country, be involuntarily confined to psychiatric hospitals and
25 would in no way qualify for intermediate levels of care like residential treatment.
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1 24. Thus, UBH's LOC Guidelines for Mental Health Conditions: Residential
2 Treatment (2013), explains that "[r]esidential services are delivered in a facility or a
3 freestanding Residential Treatment Center that provides overnight mental health services to
4 members who do not require 24-hour nursing care and monitoring offered in an acute inpatient
5 setting but who do require 24-hour structure." These guidelines make it clear that residential
6 treatment is only appropriate if the patient "is not at imminent risk of serious harm to self or
7 others," precisely because such patients should be admitted to a hospital.

9 25. In order to qualify for coverage under these guidelines, a patient must meet one of
10 three criteria: (a) the member is experiencing a disturbance in mood, affect, or cognition
11 resulting in behavior that cannot be safely managed in a less restrictive setting; (b) there is an
12 imminent risk that severe, multiple and/or complex psychosocial stressors will produce
13 significant enough distress or impairment in psychological, social, occupational/educational, or
14 other important areas of functioning to undermine treatment in a lower level of care; or (c) the
15 member has a co-occurring medical disorder or substance use disorder which complicates
16 treatment of the presenting mental health condition to the extent that treatment in a Residential
17 Treatment Center is necessary.

19 26. Additionally, these guidelines call for denial of coverage if treatment "can be
20 safely provided in a less intensive setting." UBH's Level of Care Guidelines, Continued Service
21 Criteria (2013), similarly specifies that coverage should be denied for any level of care unless a
22 patient can prove that he will "imminent[ly]" suffer a "significant deterioration in functioning"
23 if treated at a lower level of care.

25 27. Although UBH recently promulgated revised "2014 Level of Care Guidelines,
26 Residential Treatment Center," these revised guidelines continue to require evidence that
27 "factors leading to admission cannot be safely, efficiently *or* effectively assessed and/or treated
28

1 in a less intensive setting due to *acute changes* in the member's signs and symptoms and/or
 2 psychosocial and environmental factors."

3 28. UBH has also developed Coverage Determination Guidelines ("CDG") for mental
 4 health disorders, including a 2012 CDG for Residential Treatment Center for Major Depressive
 5 Disorder and a 2013 CDG for Treatment of Major Depressive Disorder and Dysthymic
 6 Disorder. These guidelines define "residential treatment facilities" in the same way as UBH's
 7 LOC Guidelines for Mental Health Conditions: Residential Treatment (2013). UBH's 2012 and
 8 2013 CDGs further provide that coverage for residential treatment should be discontinued
 9 unless the claimant provides "*compelling evidence* that continued treatment in the current level
 10 of care is required to prevent acute deterioration or exacerbation of the [claimant's] current
 11 condition." (emphasis added)
 12

13 29. The 2012 CDG and 2013 CDG apply the same admission criteria as that
 14 identified in UBH's LOC Guidelines for Mental Health Conditions: Residential Treatment
 15 (2013), with one notable exception. Although prevailing standards of care with respect to mental
 16 health treatment did not change between April 2012 and July 2013, the dates when UBH
 17 published its 2012 CDG and its 2013 CDG, UBH entirely excised the following language from
 18 its 2012 CDG:
 19

20 Intermediate or long-term residential services may be available with less intensity
 21 or less intensive staff support to members who are recovering from severe and/or
 22 chronic MDD.

23 Intermediate or long-term residential services for patients who are recovering
 24 from severe and/or chronic MDD may include psychotherapy, pharmacotherapy,
 25 and other interventions aimed at supporting recovery such as the development of
 26 recovery plans and advance directives, strategies for identifying and managing
 early warning signs of relapse, development of self-management skills, and the
 provision of peer support services.

27 In cases where there is an unsupportive or high risk living situation undermining
 28 the patient's recovery efforts, intermediate or long-term residential services may

1 be provided for continued stabilization and treatment.

2 30. Generally accepted standards of assessing the appropriate level of mental
3 healthcare for minors, such as Plaintiff Natasha Wit and Plaintiffs Holdnak and Flanzraich's
4 daughters, are promulgated by the American Academy of Child and Adolescent Psychiatry
5 ("AACAP") and by the American Association of Community Psychiatrists ("AACP").
6 Generally accepted standards of assessing the appropriate level of mental healthcare for adults
7 are promulgated by AACP. These standards are publicly available. UBH acknowledges, in a
8 document entitled "Guideline Evidence Base for Level of Care Guidelines," that AACAP and
9 AACAP set the generally recognized criteria for mental health residential treatment levels of care.
10

11 31. In the same document, UBH asserts that the "evidence base" that supports its
12 Mental Health: Residential Treatment-related LOCs are the AACAP and AACP standards.
13 Similarly, in its "Introduction to the 2014 Level of Care Guidelines," UBH asserts that its
14 guidelines "reflect [UBH's] understanding of current best practices in care" and that using those
15 guidelines "reduces undesirable variation from evidence-based practice." In fact, however,
16 UBH's guidelines are inconsistent with, and much more restrictive than, evidence-based
17 generally accepted standards of care.
18

19 32. AACAP's Practice Parameter for the Assessment and Treatment of Children and
20 Adolescents With Depressive Disorders explains that the appropriate level of care is driven by a
21 multitude of considerations, including "the subject's age and cognitive development, severity
22 and subtype of depression, chronicity, comorbid conditions, family psychiatric history, family
23 and social environment, family and patient treatment preference and expectations, cultural
24 issues, and availability of expertise in pharmacotherapy and/or psychotherapy." AACAP adds
25 that "the decision for the level of care will depend primarily on level of function and safety to
26 self and others, which in turn are determined by the severity of depression, presence of suicidal
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1 and/or homicidal symptoms, psychosis, substance dependence, agitation, child and parents'
2 adherence to treatment, parental psychopathology, and family environment.”

3 33. The Child and Adolescent Level of Care Utilization System (CALOCUS), now
4 also known as CASII, is a “dimensional rating system used to determine the intensity of a child
5 or adolescent’s service needs” developed by AACAP and AACP. CALOCUS has six
6 dimensions: (1) risk of harm; (2) functional status; (3) co-morbidity; (4) recovery environment;
7 (5) resiliency and treatment history; and (6) acceptance and engagement. “Each dimension has a
8 five point rating scale, from least to most severe. For each of the five possible ratings within
9 each dimension, a set of criteria is clearly defined. Only one criterion needs to be met for that
10 rating to be selected, and for each dimension, the **highest rating** in which at least one of the
11 criteria is met is the rating that should be assigned.” A rating of 4 out of 5 in **any** of the first
12 three dimensions automatically necessitates placement in residential treatment, independent of
13 any other factors. CALOCUS notes, “[i]n most cases, the higher level of care should be
14 selected, unless there is a clear and compelling rationale to do otherwise.”

15 34. Similarly, the Level of Care Utilization System for Psychiatric and Addictive
16 Services (“LOCUS”), developed by AACP for use in adult populations, notes: “[T]he highest
17 score in which it is more likely than not that at least one criterion has been met should generally
18 be assigned. **The result will be that any errors will be made on the side of caution . . . In most**
19 **cases, the higher level of care should be selected, unless there is a clear and compelling**
20 **rationale to do otherwise.”**

21 35. CALOCUS explicitly adds that “it may be desirable for a child or adolescent to
22 remain at a higher level of care to preclude relapse and unnecessary disruption of care, and to
23 promote lasting stability.”

1 36. Prolonged residential treatment is in fact the normal prescribed course of
2 treatment for children and adolescents suffering from mental illness. According to SAMHSA,
3 the average length of stay in a residential treatment center for children with mental illness is
4 over six months.

5 37. UBH's LOCs and CDGs related to residential treatment for mental illness are
6 inconsistent with generally accepted standards of care in four key respects. First, UBH's
7 guidelines require a patient to demonstrate by "compelling evidence" that residential treatment
8 is necessary to prevent "acute" deterioration of condition. Generally accepted standards of care,
9 in contrast, call for residential treatment ***unless*** there is "clear and compelling" evidence that a
10 lower level of care is more appropriate (*i.e.*, the burden of proof is reversed), ***do not*** condition
11 residential treatment on the acute risk of deterioration, and instead focus on the long-term
12 benefits of residential treatment, recognizing that a multi-month regimen of such treatment is
13 often necessary to address chronic conditions and promote lasting stability. Second, UBH's
14 guidelines require a patient to demonstrate she has experienced "acute changes" in her
15 condition or circumstances that now warrant residential treatment, even though generally
16 accepted standards articulate ***no such requirement*** and call for residential treatment when
17 chronic symptoms are present. Third, UBH's guidelines ignore generally accepted and
18 evidence-based assessment protocols and rating systems for determining whether residential
19 treatment is appropriate. Fourth, UBH's guidelines do not distinguish between adult and
20 adolescent patients, and therefore ignore generally accepted standards of care which recognize
21 adolescents' need for different treatment consistent with their level or maturity and need for
22 continuing development.
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UBH'S IMPROPER DENIAL OF THE WITS' CLAIMS

38. Plaintiffs David Wit, and his daughter Natasha Wit, reside in Larchmont, New York. Natasha Wit turned 18 on August 10, 2013.

39. David Wit is a participant in the "Insperity Group Health Plan" (the "Wits' Plan") and Natasha Wit is a beneficiary of the Wits' Plan. This non-grandfathered, large group plan is a fully-insured healthcare policy issued by UHIC in Texas with an effective date of January 1, 2013. It is subject to ERISA and Texas state law.

40. According to the Certificate of Coverage ("COC") that governs the Wits' Plan, all benefits are paid pursuant to the terms of the Wits' Plan, which is "issued" and "insured" by UHIC. The Wits' COC identifies the "Plan Sponsor" and "Named Fiduciary" as Insperity Holdings, Inc. The COC explains, however, that the Plan Sponsor retains all fiduciary responsibilities with respect to the Plan "except to the extent the Plan Sponsor has delegated or allocated to other persons or entities one or more fiduciary responsibility with respect to the Plan." It then explains that UHIC is the "Claims Fiduciary." In that capacity, the COC explains that the plan is "administered on behalf of the Plan Administrator by UnitedHealthcare Insurance Company" and that, as such, UHIC handles "claims processing, claims payment, and [] appeals." It further explains that UHIC has discretion to "interpret benefits under the Policy," interpret the other terms, conditions, limitations and exclusions set out in the Policy, and "make factual determinations related to the Policy and its Benefits." It also explains that UHIC "may delegate this discretionary authority to other persons or entities that provide services in regard to the administration of the Policy." Pursuant to that authority, UHIC has delegated all of its discretion to UBH for purposes of making mental health-related claims administration.

1 41. The Wits' insurance policy pays benefits for in- and out-of-network, residential
2 mental health treatment consistent with generally accepted medical practices.

3 42. The Wits' insurance policy provides for one internal appeal prior to the
4 exhaustion of administrative remedies.

5 43. On April 29, 2013, Natasha Wit, then 17 years old, was admitted to Monte Nido
6 Vista, in Agoura Hills, California, for treatment of depression, anxiety, obsessive-compulsive
7 behaviors, a severe eating disorder, medical complications (including amenorrhea, adrenal and
8 thyroid problems, vitamin deficiency, and gastrointestinal symptoms), failure of symptom self-
9 management (including restricting behaviors and precipitous weight loss), and a lack of
10 psychosocial support (due to severe social isolation).

11 44. Monte Nido Vista is licensed by the State of California as a Residential Treatment
12 Facility and accredited for Behavioral Health Care by the Joint Commission of Accreditation of
13 Hospitals Organization ("JCAHO"), which has also awarded it the "Gold Seal of Approval."
14 Monte Nido Vista is an in-network provider with UBH.

15 45. Despite the extensive clinical information conveyed by Monte Nido Vista to UBH
16 upon Natasha's admission, by letter dated May 3, 2013, UBH's Associate Medical Director,
17 Theodore A. Allchin, promptly denied Natasha's claim for coverage for treatment at Monte
18 Nido Vista from April 30, 2013 forward:

19 United Behavioral Health (UBH) is responsible for making benefit coverage
20 determinations for mental health and substance abuse services that are provided to
21 United Healthcare Insurance Company members.

22 [I]t is my determination that the member's treatment does not meet the medical
23 necessity criteria for residential mental health treatment per **UBH Level of care**
24 **Guidelines for Residential Mental Health** treatment from April 30, 2013
25 forward. [Natasha] is not a **serious risk of harm to herself or others**. Her weight
26 is appropriate. There are **no acute medical issues**. There's no evidence of the need
27 for **24-hour monitoring**. It would appear that the patient could **safely** be treated at
28 a less restrictive level of care such as partial hospitalization."

1 46. Although UBH referenced its “Level of Care Guidelines for Residential Mental
 2 Health,” many of the criteria it identified as a basis for denying coverage were improperly
 3 drawn from UBH’s Level of Care Guidelines for Acute Inpatient Mental Health Treatment (*i.e.*,
 4 alleged lack of “serious risk of harm to herself or others,” “no acute medical issues,” and
 5 absence of need for “24 hour clinical monitoring”). Moreover, UBH denied coverage because
 6 Natasha could allegedly be “safely” treated in a less restrictive setting without giving any
 7 consideration as to whether such treatment would be equally effective or offering a clear and
 8 compelling rationale for not approving the prescribed higher level of care, as required under
 9 generally accepted standards. UBH also justified its denial on Natasha’s allegedly “appropriate”
 10 weight, although weight is not necessarily the primary treatment consideration for eating
 11 disorders other than anorexia nervosa and Natasha was not being treated for anorexia nervosa at
 12 Monte Nido.

13 47. In response to an urgent appeal by Monte Nido Vista on May 1, 2013, UBH’s
 14 Medical Director, Roxane Sanders, issued a final adverse determination letter dated May 3,
 15 2013:

16 United Behavioral Health (UBH) is responsible for making benefit coverage
 17 determinations for mental health and substance abuse services that are provided to
 18 United Healthcare Insurance Company members.

19 * * *

20 It is my decision based on the clinical information including live review, and the
 21 ***UBH Level of Care Guidelines for Acute Inpatient Mental Health Treatment*** to
 22 uphold the denial as it appears that [Natasha] could be treated in a less restrictive
 23 setting. [Natasha] has no documented ***immediate risk of harm to herself or others***
 24 that requires ***24-hour monitoring*** for treatment. [Natasha] has no medical
 25 conditions that require ***24-hour monitoring or treatment***. It appears that your
 26 child has the strengths to work cooperatively with her providers toward her
 27 recovery. It appears that your child does not require the intensity of a residential
 28 treatment program. Your child has access to treatment any [sic] less restrictive
 setting in your community such as Partial Hospitalization which would be

1 authorized according to benefit [sic].

2 * * *

3 This is the Final Adverse Determination of your internal appeal. All internal
4 appeals through UBH have been exhausted.

5 48. Unlike Dr. Allchin, who purported to apply UBH's Level of Care Guidelines for
6 Residential Mental Health treatment, but then covertly relied in part upon criteria from UBH's
7 LOC Guidelines for Acute Inpatient Mental Health Treatment, Dr. Sanders took the opposite
8 approach. She acknowledged that she was applying "UBH Level of Care Guidelines for Acute
9 Inpatient Mental Health Treatment" to deny the appeal, even though that guideline is
10 inapplicable to the residential treatment being sought.
11

12 49. Thus, although UBH's mental health LOC Guidelines clearly distinguish between
13 "Acute Inpatient" and "Residential Treatment" and their respective admission criteria, and the
14 Wits just as clearly sought residential treatment, UBH's practice was to condition coverage on
15 Natasha's inability to satisfy two inapplicable acute inpatient criteria: the need for 24-hour
16 nursing care and monitoring and the requirement that the member pose an imminent risk of
17 serious harm to themselves or others. Moreover, contrary to prevailing medical standards, UBH
18 failed to provide clear and compelling rationales for not approving the prescribed, higher level
19 of care, shifted the burden to Natasha to provide compelling evidence that imminent or acute
20 harm would occur in a lower level of care, and almost exclusively focused on the alleged
21 absence of "acute" circumstances in denying residential treatment.
22

23 50. Despite the illegal benefits denials and the resulting financial expense nearing
24 \$30,000, the Wits paid for and Natasha received the prescribed course of residential treatment
25 through June 28, 2013. Given her mental illness, it is likely that she will need residential
26 treatment at some time in the future.
27

UBH'S IMPROPER DENIAL OF HOLDNAK'S CLAIMS

51. Plaintiff Cecilia Holdnak and her minor daughter, “Emily,”¹ reside in Scottsdale, Arizona.

52. Plaintiff Holdnak is a participant in the self-funded, non-grandfathered, large group plan sponsored by American Express Company (“the AMEX Plan”), which is governed by ERISA. Her daughter, Emily, is an AMEX Plan beneficiary.

53. The AMEX Plan identifies American Express Company as the “Plan Administrator.” According to the AMEX Plan, “American Express and the Plan Administrator are solely responsible for: Enrollment and classification changes (including classification changes resulting in [participant] enrollment or the termination of [participant] coverage); and Notifying [a participant] of the termination or modifications to the Medical and Prescription Drug Plans.”

54. The AMEX Plan then identifies UHIC is the “Claims Administrator” with “the discretionary authority and fiduciary responsibility under ERISA to make claim determinations and to provide a full and fair review of appealed claims including determining any final appeals of claims.” The AMEX Plan then adds that “[t]he Claims Administrators, also known as claims fiduciaries, make all claims decisions.”

55. For all claims and appeals, the AMEX Plan provides that the “Claims Administrator has the sole and exclusive discretion to: (1) interpret benefits under the Plan; (2) interpret the other terms, conditions, limitations, and exclusions of the Plan, including this handbook, any summary plan description, and any summaries of material modification; and (3) make factual determinations related to the Plan and its benefits.” With respect to mental health

¹ Because Plaintiff Holdnak’s daughter is a minor, the pseudonym “Emily” is used throughout.

1 and substance abuse-related claims, UHIC has delegated all of its fiduciary authority under the
2 AMEX plan to adjudicate claims to UBH.

3 56. The AMEX Plan expressly provides: “ERISA imposes duties upon the people
4 who are responsible for the operation of an employee benefit plan. The people who operate your
5 Plan, called ‘fiduciaries’ of the Plan, have a duty to do so prudently and in the best interest of
6 you and other Plan participants and beneficiaries.”

7
8 57. The AMEX Plan provides for two levels of internal appeals for denied claims,
9 after which plan participants are entitled to sue. Pursuant to the terms of the plan, appeals may
10 not be adjudicated by the same persons who make initial claims denials.

11 58. The AMEX Plan covers in- and out-of-network services, including residential
12 mental health and substance abuse treatment “consistent with generally accepted medical
13 practice for the treatment of such conditions.”

14
15 59. Among the covered services available to Plaintiff Holdnak and her daughter
16 through their plan is residential treatment for mental illness.

17 60. Now 15 years old, Emily Holdnak, a former honors student, was psychiatrically
18 hospitalized on April 19, 2013 for cutting her wrists with a razor, following years of
19 unsuccessful outpatient mental health treatment, including personal psychotherapy, family
20 counseling, and psychotropic medications. Emily’s depression, problems at school, and parents’
21 divorce resulted in unmanageable symptoms according to UBH’s internal case records.
22 Subsequent to her daughter’s discharge on April 25, 2013, Plaintiff Holdnak discovered
23 numerous writings about suicide by Emily, including plans to take her life by cutting and
24 hanging. After consultation with Emily’s outpatient mental health providers, Emily was
25 rehospitalized from October 9, 2013 through October 17, 2013.
26
27
28

1 61. Meanwhile, Emily's outpatient providers opined that Emily was not making
2 expected progress and that her course of outpatient treatment was not working. They expressed
3 concern that Plaintiff Holdnak's efforts to monitor and protect Emily from self-harm were not
4 sustainable and damaging to their relationship. Residential treatment for Emily was therefore
5 recommended in writings forwarded to UBH.
6

7 62. On December 10, 2013, Emily again attempted suicide by overdosing on
8 narcotics prescribed to her following surgery. When Emily's outpatient providers learned of her
9 December 11, 2013 hospital admission, Plaintiff Holdnak was advised that Emily could not
10 remain in their care due to Emily's high risk and need for residential treatment. Emily's school,
11 likewise, informed Plaintiff Holdnak that Emily could not return until successfully discharged
12 from residential treatment.
13

14 63. On December 13, 2013, upon the specific recommendation of her outpatient
15 providers, Emily was admitted to Solacium New Haven Treatment Center ("New Haven") in
16 Spanish Fork, Utah.

17 64. New Haven is licensed as a residential treatment facility by the Utah Department
18 of Human Services and is accredited by JCAHO, which has also awarded it the "Gold Seal of
19 Approval." New Haven is an out-of-network provider with UBH.
20

21 65. Upon admission at New Haven, Emily was diagnosed with Major Depressive
22 Disorder, obesity, problems related to the social environment, and assigned a Global
23 Assessment of Functioning ("GAF") score of 35/100, indicative of impairment in reality testing,
24 communication, or major impairment in several areas such as school, family relations,
25 judgment, thinking, or mood. New Haven also assessed that conflict between Emily's divorced
26 parents complicated her recovery environment.
27

66. Nonetheless, when New Haven informed UBH case manager Kenneth Young on December 19, 2013 that Emily claimed to be “suicidal all the time” on her pre-admission online postings, that “[s]he’s a planner, she doesn’t tell anyone,” and that the estimated length of residential treatment could span 9 months, Mr. Young immediately “advised the projected [L]OS [length of stay] falls outside of the benefit for *acute care* MH RTC, and that if facility and family are committed to ELOS [(estimated length of stay) they] should prepare to explore secondary or self-funding once member no longer meets CDG [Coverage Determination Guideline].”

67. Thus, Mr. Young identified UBH’s practice of applying “acute” care criteria by systematically classifying residential treatment as “acute care” when making benefit determinations, and thereby exempting chronic mental health conditions, irrespective of severity, from residential treatment coverage.

68. In the same vein, by January 3, 2014, UBH Associate Medical Director, Bernard Dicasimirro, D.O., had concluded that, despite Emily’s continued “urges for self-harm” and New Haven “staff keeping [her] on close observations due to not trusting [her],” Emily did not “require the type of *acute psychiatric services offered in a mental health residential program*,” that Emily “may require more supervision which you can offer in your home,” and her “care could continue with outpatient providers, which is a covered benefit and is available locally.” Thus, as prophesied by Mr. Young, Dr. Dicasimirro conditioned Emily’s continued residential treatment coverage on the need for acute psychiatric services.

69. UBH’s case records reveal that when Mr. Young informed Emily’s mother of UBH’s denial of coverage effective January 4, 2014, Plaintiff Holdnak responded that residential treatment had been recommended by Emily’s entire outpatient treatment “team because she was not improving” and “that this is not by her choice and that she wants [Emily] to

1 be home with her safe as soon as reasonably possible.” Indeed, Mr. Young’s records corroborate
2 that Emily’s mother had “been participating in family sessions” both at New Haven and online.

3 70. On January 6, 2014, UBH Associate Medical Director, Frank James, M.D.,
4 completed an urgent appeal and overturned Dr. Dicasimirro’s denial because “the treating
5 psychiatrist did not feel it safe for [Emily] to be treated at a lesser restrictive setting” and that
6 the “family plans to visit the facility for intensive family therapy to assess safety and discharge
7 planning.”
8

9 71. On January 13, 2014, Mr. Young noted in the UBH case file that Emily cut
10 herself with a blade from a pencil sharpener. Mr. Young further noted that Emily “[p]rogressed
11 10-15 perce[n]t ‘out [of] that dark place of suicidal ideation.’” Though Emily’s most recent
12 “family session went well,” Mr. Young noted that her parents were divorced and that Emily’s
13 “father [was] struggling to complete assignments.”
14

15 72. On January 17, 2014, Mr. Young noted in the UBH case file that Emily had been
16 diagnosed with Major Depressive Disorder, Generalized Anxiety Disorder, Eating Disorder
17 NOS [Not Otherwise Specified], borderline tendencies, parent-child relational problem, and
18 problems related to the social environment. He further noted that Emily reported continued
19 suicidal ideation “94%” of the time, and that a New Haven psychological evaluation concluded
20 that Emily was “in danger of taking her life.” Mr. Young therefore concluded that Emily
21 “demonstrated inability to CFS [care for self] in less structured setting.”
22

23 73. By January 23, 2014, Mr. Young revised the UBH case file to reflect that Emily’s
24 suicidality was “chronic” and that “[Emily] states he[r] greatest weakness is that she doesn’t
25 want to live, her worst action has been hurting her mother by trying to kill herself.” Mr. Young
26 also noted that the recent “[p]arent weekend was ‘successful’, both parents present, ‘Interesting
27 interactions between mother and [Emily]. Mother very enmeshed and overinvolved, dad
28

1 disassociated or isolated.” Mr. Young reasoned that “[a]dditional time was therefore needed to
2 secure safe discharge options, solidify safety plan with recurring SI [suicidal ideation].”

3 74. On January 28, 2014, UBH medical director James Feussner, M.D., who had
4 never interviewed, met, or treated Emily, entered the following prescriptive note in the UBH
5 case file: “After reviewing this case I find that she may need more aggressive use of medication
6 in order to be stable in the community . . . Patient may improve with low-dose neuroleptic in
7 addition to her current medication.”

8 75. The following day, Mr. Young noted in the UBH case file that Emily “has had
9 su[i]cidal thought and intent 7x/day on average since Sunday. No SIB [self-injurious behaviors]
10 on the unit. Thinks about getting run over by the train.” He also noted Emily’s “Core issues ‘I’m
11 a burden and I shouldn’t whine to tell people what’s happening, so then she starts planning.’
12 Trying to pull into supporting self, mind-body connection. Passed all classes (A & A-).” Mr.
13 Young further indicated that weekly family sessions had continued, that Emily found these very
14 reassuring, and that while Emily’s mother agreed to her own individual therapy, her father had
15 refused.”

16 76. Following another staffing round with Dr. Feussner on January 29, 2014, Mr.
17 Young concluded that UBH’s coverage criteria was not met since Emily’s “suicidality appears
18 to be chronic, potentially requiring long term custodial care which falls outside of the benefit.”
19 Thus, Dr. Young improperly twisted the clear need for residential care to treat Emily’s chronic
20 mental health conditions into a need for “custodial” care, so as to justify a denial of coverage.
21

22 77. On January 30, 2014, UBH Associate Medical Director Frank James, M.D. noted
23 that Emily’s “current clinical symptoms consist of chronic suicidal ideations daily requiring
24 restrictions, 1:1 attention and no privileges.” He further noted:
25
26
27

1 Txist [therapist] is working on reducing enmeshment with mother, and improving
 2 communication style of father (not criticizing mbr [member] weight). Mother has
 3 agreed to do her own 1:1 therapy, father has refused. Facility current ELOS is
 4 through October 2014, after which mbr would return to home and OP [outpatient]
 providers. UR [Utilization review] states mbr still falls too easily into her suicidal
 mind, and due to desire to not be a burden to family would likely re-attempt.

5 * * *

6 I did a previous Urgent Appeal Overturn three weeks ago to cover the family
 7 intervention week for the family to attend in Utah. There has been no progress
 8 with the family since then. There have been no medication changes. There has
 been no progress in the member's acute suicidality and need for constant 1:1
 observation.

9 * * *

10 Specifically:

- 11 1. The care provided going forward has no reasonable likelihood or resulting in
 12 significant improvement in the member's baseline behaviors so as to safely
 13 step down to a less restrictive level of care for continued improvement and
 eventual return to home and the community within a reasonable time frame.
- 14 2. Continued services are custodial in nature based on the member's benefit
 package for acute mental health residential rehabilitation level of care.

15 78. Although Dr. James recognized Emily's persistent, "acute suicidality" and her
 16 parents' continued involvement in her care, his insistence on medication changes (again, outside
 17 the purview of a non-treating insurance reviewer), and the need to see rapid progress from her
 18 deeply fractured family, and prompt, significant improvement from such a sick child, was
 19 entirely predicated on UBH's improper standards for residential treatment and misapplication of
 20 Emily's benefit package, which explicitly recognizes residential treatment as "intermediate
 21 care" and does not categorize it as "acute mental health residential rehabilitation." As with Dr.
 22 Young, Dr. James further mischaracterized the need as "custodial" in nature, thereby creating an
 23 excuse for denial.
 24

25 79. Disregarding the express and unambiguous terms of the AMEX Plan, Dr. James
 26 issued the following January 31, 2014 denial:
 27

1 United Behavioral Health (UBH) is responsible for making benefit coverage
 2 determinations for mental health and substance abuse services that are provided to
 3 UBH members. The availability of benefit coverage for a service is determined
 4 by the terms of your benefit plan. To review information about your specific plan
 coverage, please refer to the benefit information provided by your employer
 group.

5 I have determined that coverage is not available under your child's benefit plan for
 6 the following reason(s):

7 * * *

8 You presented to the residential rehabilitation level of care the primary
 9 disturbance in mood and anxiety in Utah on 12/13/2013. After talking with your
 10 doctor's assistant, continued treatment for your mental and behavioral health
 11 issues ***no longer require acute attention*** to the issues that brought you into this
 level of care, and have ***not significantly responded*** [] his intensity and frequency
 of ***24-hour psychiatric and nursing monitoring*** provide[d] since admission.

12 * * *

13 After talking with your child's doctor, your child has only been able to progress to
 14 the extent [s]he continues to demonstrate baseline mood and behaviors. In
 15 addition, there is also the report that family members back in your child's home
 state of Arizona are not following the facility's recommendation for treatment
 while your child resides in Utah.

16 This does not mean that you could not receive further treatment. Instead, you
 17 could continue care with Mental Health Outpatient Providers in consultation with
 the facility providing continued custodial care and/or long-term placement.

18 Based on our ***Coverage Determination Guideline for Residential Treatment***
 19 ***Center Major Depressive Disorder and Dysthymic Disorder*** it is my
 20 determination that no authorization can be provided from 01/31/2014 and
 forward.

21 80. Thus, UBH denied Emily's claim because she was not experiencing an "acute"
 22 phase of her mental illness and because she was not getting better fast enough in residential
 23 treatment. These requirements are not found in the Holdnaks' plan, or in any generally accepted
 24 standards of care. Such standards recognize that residential care is appropriate to treat chronic
 25 conditions and that such care is medically appropriate for a much longer length of time than
 26 UBH's guidelines and practices allowed. Indeed, at this point Emily had been in residential
 27

1 treatment for less than a quarter of the average length of residential treatment among
2 adolescents, according to SAMHSA. Moreover, UBH denied Emily's claim based upon its own
3 CDG, which the plan does not identify as a basis for application of any exclusions.

4 81. Although Plaintiff Holdnak's Plan and ERISA forbid appeals determinations by
5 initial claims reviewers, on January 31, 2014, UBH assigned New Haven's urgent appeal of Dr.
6 James' January 30, 2014 adverse determination back to Dr. Dicasimirro, who initially denied
7 Emily's residential treatment on January 3, 2014 and whose decision was subsequently reversed
8 by Dr. James on January 6, 2014.

9 82. According to Dr. Dicasimirro's records:

10 The patient lives primarily with her mother. Her parents are divorced and she has
11 visitation with father. Her parents are noted as supportive but overbearing. The
12 facility indicates that mother is enmeshed and father has very negative
13 interactions with the patient . . . The patient is noted to have had two prior
14 inpatient admissions in 2013. She has been seeing outpatient providers two to
15 three times a week.

16 Course of Treatment: The patient's medications have been adjusted. She is
17 currently taking Prozac 40 mg. q.d. and Lamictal 50 mg. q.d. Family sessions are
18 being done by phone or Skype 90 minutes weekly. The discharge plan is for the
19 patient to return home to family with outpatient providers. The therapist is
20 working on reducing enmeshment with mother and improving communication
21 with father. The family has attended family intervention week. The patient
22 continues to endorse suicidal ideation, reporting that she has suicidal thoughts and
23 intentions seven times a day on average. The AP [Attending Physician] indicates
24 that the patient is no longer on one-to-one supervision. The parents have made
25 limited progress thus far. The patient continues to express suicidal ideation and
26 intent on a daily basis. He plans to refer the patient back to psychiatry to see if
27 medication adjustments could be helpful. He anticipates that the patient will
28 remain at residential treatment through the fall of 2014.

83. While Dr. Dicasimirro's notes reflect that Emily's medications had, in fact, been
adjusted, that her family was making limited progress, and that Emily was improving as
evidenced by the fact that she no longer required on one-to-one supervision – and thus negate

1 each of Dr. James' internal (albeit unjustified) bases for denying Emily's continued care – Dr.
2 Dicasimirro nonetheless denied the urgent

3 84. Not only did Dr. Dicasimirro fail to consult the relevant benefit document for
4 Emily, who was covered by the AMEX Plan and who has never been a "Railroad Employees"
5 plan beneficiary, but his assertion that "acute treatment" was a precondition to residential
6 coverage is flatly belied by the AMEX Plan categorizing residential treatment as "intermediate"
7 care that is covered where it is consistent with generally accepted standards of care. Moreover,
8 his boilerplate assertion that Emily's residential treatment was not "consistent with generally
9 accepted standards of practice" is unsupportable given that such standards call for residential
10 treatment for chronically ill patients, recognize that such treatment is often medically
11 appropriate for several months, and do not require "acute" changes in a patient's symptoms or
12 circumstances to render residential treatment medically necessary.
13

14
15 85. In a February 7, 2014 follow-up with New Haven regarding Emily's "discharge
16 date," UBH case manager Kenneth Young noted that "Father is still not seeing therapist, mother
17 is following through with all requests. [Emily] is making *significant progress and is doing*
18 *'amazing work'*. ELOS remains 9+ months due to history and 'she has a good front'."

19 86. On February 21, 2014, when challenged about the failure to approve residential
20 treatment for Emily, UBH case manager Rhoda Scott "began to offer suggestions as to
21 alternative funding through state or local resources," confirming that UBH self-servingly
22 attempts to shift responsibility for its insureds' mental health coverage to already strained public
23 resources.
24

25 87. In a final exercise of futility, on March 25, 2014, Plaintiff Holdnak submitted a
26 voluminous, second level written appeal to UBH, which was denied by Associate Medical
27

Director Neal R. Satten, M.D. on April 7, 2014 in a “A Final Internal Non-Coverage Determination.”

United Behavioral Health (UBH) is responsible for making benefit coverage determinations for mental health and substance abuse services that are provided to UBH members.

* * *

After fully investigating the substance of the appeal/ grievance, including all aspects of clinical care involved in this treatment episode I have determined that benefit coverage is not available for the following reason(s):

You presented to the residential rehabilitation level of care the primary disturbance in mood and anxiety in Utah on 12/ 13/2013. After talking with your doctor's assistant, continued treatment for your mental and behavioral health issues no longer require *acute attention* to the issues that brought you into this level of care, and have not significantly responded the intensity and frequency of *24-hour psychiatric and nursing monitoring* provide[d] since admission.

After talking with your child's doctor, your child has only been able to progress to the extent he continues to demonstrate baseline mood and behaviors. In addition, there is also the report that family members back in your child's home state of Arizona are not following the facility's recommendation for treatment while your child resides in Utah. As such, your child's providers have determined that your child will need long-term placement with an estimated length of stay of 9 months, and assistance with daily care needs, as your child are unable to maintain safety in a less restrictive level of care going forward, and in the community.

This does not mean that you could not receive further treatment. Instead, you could continue care with Mental Health Outpatient Providers in consultation with the facility providing continued custodial care and/or long-term placement.

Based on our *Coverage Determination Guideline for Residential Treatment Center Major Depressive Disorder and Dysthymic Disorder* it is my determination that no authorization can be provided from 01/31/2013 and forward.

88. Dr. Satten’s boilerplate appeal denial bears a striking resemblance to Dr. James’ January 31, 2014 denial letter. Both letters justified UBH’s denial on the ground that Emily was not experiencing an acute condition and that she was not getting better fast enough – although Mr. Young had reported that Emily was making “significant progress” and despite there being no such requirement pursuant to generally accepted standards for residential mental health

1 treatment. Moreover, Dr. Satten perversely relied upon the fact that Emily's non-custodial father
2 was refusing treatment as a ground for denying her claim, even though generally accepted
3 standards recognize that family instability weighs *in favor* of residential treatment, and that, in
4 any event, Emily did not live with her father. Moreover, both denials relied upon UBH's CDG,
5 even though her plan did not authorize UBH to exclude otherwise available coverage on the
6 basis of this type of guideline.
7

8 89. Dr. Satten's logged case notes demonstrate the real reason that UBH denied the
9 claim: "LOS [Length of Stay] outside benchmark for condition and treatment." No such
10 "benchmark" appears in the AMEX Plan or UBH's LOCs or CDGs. Moreover, such an
11 evidently short length of stay benchmark is clearly incompatible with generally accepted
12 standards: not only do those standards make no reference to length of stay limits, the average
13 course of residential treatment for adolescents last several months longer than the brief
14 residential treatment stay UBH approved for Emily.
15

16 90. As a result of UBH's improper practices described above, Plaintiff Holdnak has
17 incurred over \$100,000 of out-of-pocket costs and continues to incur substantial expenses to
18 fund her daughter's critically needed residential treatment, which Emily continues to receive.
19

20 91. Given her condition, it is likely that Emily may require residential treatment for
21 her mental health disorders in the future, and that she will submit such claims to UBH pursuant
22 to her insurance plan.

23 **UBH'S LEVEL OF CARE AND COVERAGE DETERMINATION GUIDELINES**
24 **RELEVANT TO PFEIFER, MUIR, AND FLANZRAICH'S CLAIMS**

25 92. UBH has developed CDGs and LOCs for the treatment of substance abuse in
26 addition to those applicable to mental health treatment.
27
28

93. UBH has promulgated a “Coverage Determination Guideline for Treatment of Substance Use Disorders,” which was last modified in 2013 (“2013 Coverage Determination Guideline for Treatment of Substance Use Disorders”). This document defines “Residential Detoxification” to be “comprised of services that are provided in a residential setting other than an acute care hospital for the purpose of completing a medically safe withdrawal from alcohol or drugs.” It explains that “[r]esidential detoxification is typically indicated when withdrawal is severe enough to warrant 24-hour care, but on-site access to medical personnel is not essential.” It defines “Residential Rehabilitation” differently, and as a less restrictive and lower level of care. It defines such treatment to be “comprised of acute overnight services that are *typically* provided in a freestanding Residential Treatment Center for the care of a substance use disorder.”

94. This guideline provides the following admission criteria for residential rehabilitation:

- The member’s *use of alcohol or drugs is heavy and continuous*, and is associated with either of the following:
- Current symptoms of moderate *withdrawal* that require monitoring and management;
- Emerging symptoms or a history of use which indicates that moderate *withdrawal* is imminent and requires monitoring and management; or
- A Clinical Institute *Withdrawal* Assessment Scale (CIWA-Ar) score of 8 to 15; or
- The member has a co-occurring medical disorder or mental health condition which complicates ambulatory *detoxification* to the extent that detoxification in a Residential Treatment Center is necessary.
- The member is not at imminent risk of harm to self or others.

95. It further requires substance abuse patients in residential treatment to “provide *compelling* evidence that continued treatment in the current level of care is required to prevent acute deterioration or exacerbation of the member’s current condition.”

96. Without any corresponding change in prevailing standards for the treatment of substance abuse, this guideline omitted the following admission language from UBH’s 2011 Coverage Determination Guideline, Residential Rehabilitation for Substance Use Disorders:

A residential rehabilitation program is appropriate when a member lacks the motivation or social support system to remain abstinent, but does not require the structure and intensity of services provided in a hospital.

* * *

Patients appropriate for discharge from residential rehabilitation to the next level of care are characterized as:

- Individuals who have achieved the goals in his/her treatment plan, resolving the problem that necessitated admission and who have a demonstrated motivation to return to outpatient treatment.
- Individuals who have the ability to remain abstinent even in situations where substances are potentially available and have living situations and support systems that are conducive to remaining substance free.

97. The 2011 guideline provides that the following are “indications” that coverage exists for residential rehabilitation for substance abuse disorders:

- The patient continues to abuse substances despite appropriate motivation.
- The patient continues to use substances, and the patient’s functioning has deteriorated to the point that the patient cannot be safely treated in a less restrictive environment.
- There is a high risk of harm to self or others due to continued and severe substance use which prohibits treatment from occurring safely in a less restrictive environment.
- There is a high risk of exacerbation of medical conditions due to continued substance use which prohibits treatment from occurring safely in a less restrictive environment.

- There is a high risk of developing severe withdrawal symptoms, which cannot be safely managed in a less restrictive environment.
- The patient is experiencing withdrawal symptoms that do not compromise the patient's medical status, but family, social support systems or other resources that might otherwise prevent the need for residential treatment are impaired or not available.

98. UBH's 2013 (and preceding) Level of Care Guidelines: Substance Use Disorders: Residential Rehabilitation ("2013 Level of Care Guidelines: SUD-Rehab") condition admission to residential rehabilitation on satisfaction of any of the following six criteria:

1. The member ***continues to use alcohol or drugs***, and the member's functioning has deteriorated to the point that the member cannot be safely treated in a less restrictive level of care.

- OR -

2. The member ***continues to use alcohol or drugs***, is at risk of exacerbating a serious co-occurring medical condition, and cannot be safely treated in a lower level of care.

- OR -

3. There is a high risk of harm to self or others due to ***continued and severe alcohol or drug use*** which prohibits treatment from safely occurring in a less restrictive level of care.

- OR -

4. There is a high risk that ***continued use of alcohol or drugs*** will exacerbate a co-occurring medical condition to the extent that treatment in a less restrictive level of care cannot be safely provided.

- OR -

5. There is a high risk of developing severe ***withdrawal*** symptoms which cannot be safely treated in a lower level of care.

- OR -

6. The member is experiencing ***withdrawal*** symptoms that do not compromise the member's medical status to the extent that treatment in Acute Inpatient is indicated, but the symptoms are of extreme subjective severity and the member lacks resources or a functional social support system needed to manage the symptoms in a lower level of care.

1 99. These guidelines further require claimants to demonstrate they cannot “be safely”
2 treated in a “less intensive setting.”

3 100. UBH’s 2013 Level of Care Guidelines, Continued Service Criteria, specify that
4 coverage should be denied for any level of care unless a claimant can prove that he/she will
5 “imminent[ly]” suffer a “significant deterioration in functioning” at a lower level.
6

7 101. Strikingly, nowhere do UBH’s pre-2014 LOCs even attempt to account
8 independently for risk of relapse, motivation barriers, or social supports. Moreover, these
9 guidelines call for claim denials where a lower level of care will be safe, even if it is less
10 efficient or effective.

11 102. Moreover, taken together, UBH’s acute-focused CDGs and LOC Guidelines
12 provide that residential rehabilitation for substance abuse will only be covered when the
13 claimant is intoxicated or experiencing or likely to develop withdrawal. They preclude treatment
14 at the residential rehabilitation level of care in the absence of intoxication upon admission
15 without concurrent evidence or likelihood of withdrawal. Even with evidence of withdrawal,
16 they require immediate discharge once detoxification or withdrawal has passed. Moreover, they
17 call for denial of residential treatment coverage if it is inconsistent with UBH’s LOC Guidelines
18 or CDGs, including the requirement for a lower level of care if it is safe (even if it will not be as
19 effective as a higher level of care) or if a patient cannot provide compelling evidence of acute
20 deterioration or exacerbation of the condition at a lower level of care.
21
22

23 103. UBH promulgated new level of care guidelines for residential treatment in its
24 2014 Level of Care Guidelines, Residential Rehabilitation. These new guidelines implicitly
25 recognized that UBH’s prior guidelines were overly restrictive by, for example, explicitly
26 stating that patients who were at risk for withdrawal should not be treated in a residential
27 rehabilitation facility (because such patients should be treated in a residential detoxification or
28

1 in-patient facility). The new guidelines adopt a new methodology for determining whether
2 residential treatment will be covered – a focus on whether, in UBH’s view, residential treatment
3 is necessary at a particular time, through application of “why now” factors. However these “why
4 now” factors continue to deviate from generally accepted standards by focusing almost
5 exclusively on acute changes and conditions. The 2014 LOC guidelines require a patient to
6 prove that the “why now factors leading to admission” suggest that there is an “imminent or
7 current risk of relapse which cannot be safely, efficiently or effectively assessed and/or treated
8 in a less intensive setting” or that the “factors leading to admission cannot be safely, efficiently
9 or effectively assessed and/or treated in a less intensive setting due to *acute* changes” in the
10 patient’s symptoms or circumstances.”

12 104. Prevailing substance abuse treatment guidelines have been promulgated by the
13 American Society for Addiction Medicine (“ASAM”) and the AACP, which are publicly
14 available. UBH acknowledges, in a document entitled “Guideline Evidence Base for Level of
15 Care Guidelines” that ASAM and AACP set the generally recognized criteria for substance
16 abuse-related residential treatment levels of care. In the same document, UBH asserts that the
17 ASAM and AACP standards provide the “evidence base” that supports its Level of Care
18 Guideline for Substance Use Disorders: Residential Rehabilitation. Similarly, in its
19 “Introduction to the 2014 Level of Care Guidelines,” UBH asserts that its guidelines “reflect
20 [UBH’s] understanding of current best practices in care.” In fact, however, UBH’s guidelines
21 are inconsistent with, and much more restrictive than, these generally accepted standards of
22 care.
23
24

25 105. AACP’s guidelines are discussed above and are inconsistent with UBH’s
26 substance abuse-related guidelines. So too are ASAM’s guidelines. The ASAM guidelines not
27 only support continued residential rehabilitation for purposes of “withdrawal management,” a
28

1 treatment regime far exceeding the duration of detoxification, but also discretely account for:
 2 “emotional, behavioral, or cognitive conditions and complications,” “readiness to change,”
 3 “relapse, continued use, or continued problem potential,” and “recovery/living environment.” In
 4 fact, ASAM does not require the presence of either withdrawal or comorbid mental
 5 health/medical conditions for admission to residential rehabilitation (which it identifies as a
 6 “clinically managed level of care”):

8 Individuals who are appropriately placed in the clinically managed levels of care
 9 have minimal problems with intoxication or withdrawal (Dimension 1) and few
 10 biomedical complications (Dimension 2), so on-site physician services are not
 11 required. Such individuals may have relatively stable problems in emotional,
 12 behavioral, and cognitive conditions (Dimension 3), meeting the diagnostic
 13 criteria of the *Diagnostic and Statistical Manual of Mental Disorders (DSM)* of
 14 the American Psychiatric Association. Many also have significant limitations in
 the areas of readiness to change (Dimension 4), relapse, continued use, or
 continued problem potential (Dimension 5), or recovery environment (Dimension
 6). Therefore, they are in need of interventions directed by appropriately trained
 and credentialed addiction treatment staff. Such individuals also need case
 management services to facilitate their reintegration into the larger community.

15 106. ASAM also explicitly acknowledges that “*chronicity* of the addictive disorder or
 16 the patient’s cognitive limitations” may compromise “readiness to change” and necessitate
 17 residential treatment.

18 107. Moreover, ASAM calls for continued residential treatment if any of the following
 19 apply:
 20

21 The patient is making progress, but has not yet achieved the goals articulated in
 22 the individualized treatment plan. Continued treatment at the present level of care
 23 is assessed as necessary to permit the patient to continue to work toward his or her
 treatment goals;

24 or

25 The patient is not yet making progress, but has the capacity to resolve his or her
 26 problems. He or she is actively working toward the goals articulated in the
 27 individualized treatment plan. Continued treatment at the present level of care is
 28 assessed as necessary to permit the patient to continue to work toward his or her
 treatment goals;

and/or

New problems have been identified that are appropriately treated at the present level of care. The new problem or priority requires services, the frequency and intensity of which can only safely be delivered by continued stay in the current level of care. The level of care in which the patient is receiving treatment is therefore the least intensive level at which the patient's new problems can be addressed effectively.

108. ASAM further specifies that, with respect to residential treatment (which it describes as a Level 3 program), “[w]hile the duration of treatment varies with the severity of an individual’s illness and his or her response to treatment, the length of service in clinically managed Level 3 programs tends to be longer than in the more intensive medically monitored and medically managed levels of care Longer exposure to treatment interventions is necessary for certain patients to acquire basic living skills and to master the application of coping and recovery skills.” Underscoring this, the American Psychiatric Association Guideline for the Treatment of Patients with Substance Use Disorders, Second Edition (2006), explicitly states that “[r]esidential treatment of 3 months is associated with better long-term outcomes in such patients.”

109. Strikingly distinguished from the UBH CDG and LOC Guidelines is ASAM’s instruction that “all matrices in *The ASAM Criteria* correlate risk ratings and the types of services and modalities needed, and call for treatment where the patient’s needs can **best be met**” generally based on “[t]he dimension with the highest risk rating determin[ing] the immediate service needs and placement decision.”

110. Contrary to ASAM and AACAP’s evidence-based guidelines, UBH’s CDG and LOC Guidelines also fail to include adolescent-specific substance abuse criteria. This is especially problematic due to the special environmental factors impacting adolescent populations and the specific recommendations developed for their care. AACAP’s Practice

1 Parameter for the Assessment and Treatment of Children and Adolescents With Substance Use
2 Disorder explains:

3 Longer duration of treatment is associated with several favorable outcomes . . .
4 Control of substance use should not be the only goal of treatment. A broad
5 concept of rehabilitation involves targeting associated problems and domains of
6 functioning for treatment. Integrated interventions that concurrently deal with
7 coexisting psychiatric and behavioral problems, family functioning, peer and
8 interpersonal relationships, and academic/vocational functioning not only will
9 produce general improvements in psychosocial functioning but most likely will
10 yield improved outcomes in the primary treatment goal of achieving and
11 maintaining abstinence.

12 111. For these reasons, ASAM noted that when an insurer such as UBH develops its
13 own treatment level of care guidelines “rather than adhering to nationally validated, reliable, and
14 accepted guidelines, it may appear that decision-influencing factors such as cost considerations
15 outweigh valid evidence-based authorization requests for medically necessary treatment.”

16 112. This is precisely what happened here. UBH’s guidelines restrict coverage only to
17 situations in which the patient is experiencing “acute” conditions such as intoxication or
18 withdrawal, even though such limitations are not found in the Plaintiffs’ Plans or in generally
19 accepted substance abuse treatment guidelines.

20 113. Such systemic misapplication of medical necessity criteria with respect to
21 residential rehabilitation is not limited to UBH. On July 9, 2014, the New York State Attorney
22 General announced that it had recently settled claims against a different insurer who was
23 engaged in almost identical misconduct to that alleged here:

24 Residential treatment is a standard, recommended, evidence-based form of
25 behavioral health treatment. Offering medication, counseling and structure,
26 residential treatment facilities for behavioral health disorders provide a critical
27 intermediate level of care between acute inpatient and outpatient treatment,
28 enabling patients to transition back to living with their families. Residential
treatment programs provide an intermediate level of care as compared to inpatient
services, similar to skilled nursing treatment for medical/surgical conditions.

* * *

Emblem applies medical necessity criteria incorrectly when it reviews behavioral health-related requests and claims. For example, even though substance abuse rehabilitation is not an acute level of care, in denying requests for coverage of rehabilitation, Emblem classifies it as acute care, and in certain cases, Emblem has denied requests for coverage of substance abuse rehabilitation on the grounds that the member was not experiencing “life-threatening withdrawal,” which is not a requirement for such treatment. In fact, Emblem members who are suffering from life-threatening withdrawal require a more intensive level of care than rehabilitation, such as medically managed inpatient detoxification.

Assurance of Discontinuance Under Executive Law, Assurance No.: 14-031.

114. Pursuant to that settlement, Emblem stands to pay \$31 million in restitution to 15,000 customers and a \$1.2 million penalty.

UBH’S IMPROPER DENIAL OF PFEIFER’S CLAIMS

115. Plaintiff Brandt Pfeifer is the Executor of the Estate of Lauralee Pfeifer, his late wife. Brandt Pfeifer resides in Lake Forest, Illinois, where his wife also resided until her death on April 9, 2014.

116. Plaintiff Pfeifer is a participant in the “Continental Group Health Plan” (the “Pfeifers’ Plan”), and Lauralee Pfeifer was a beneficiary of the Pfeifers’ Plan. This non-grandfathered, large group plan is a fully-insured healthcare policy issued by UHIC-IL with an effective date of October 1, 2013. It is subject to ERISA and Illinois state law.

117. According to the Certificate of Coverage (“COC”) that governs the Pfeifers’ Plan, all benefits are paid pursuant to the terms of the Pfeifers’ Plan, which is “offered” and “underwritten” by UHIC-IL. The COC explains that UHIC may “arrange for various persons or entities to provide administration services in regard to the Policy, such as claims processing.” Pursuant to this provision, UHIC has delegated all claims adjudication-related responsibilities under the Pfeifer’s Plan to UBH.

1 118. The Pfeifers' plan pays benefits for in- and out-of-network, detoxification and
2 residential substance use disorder treatment "consistent with nationally recognized scientific
3 evidence as available, and prevailing medical standards and clinical guidelines."

4 119. The Pfeifers' Plan defines "prevailing medical standards and clinical guidelines"
5 as "nationally recognized professional standards of care including, but not limited to, national
6 consensus statements, nationally recognized clinical guidelines, and national specialty society
7 guidelines." Illinois law (215 ILCS 5/370c(b)(3)) further specifies that, with respect to all
8 substance abuse claims submitted to an Illinois-based plan such as Pfeifer's Plan, ASAM
9 guidelines must be used to determine medical necessity.
10

11 120. Claims denied by the Pfeifers' Plan are subject to one internal appeal prior to
12 exhaustion of administrative remedies.

13 121. On October 26, 2013, Lauralee Pfeifer was admitted for alcohol detoxification at
14 Passages-Malibu ("Passages"), in Malibu, California, a state licensed and JCAHO-accredited
15 residential treatment facility located near her adult children residing in California. Passages is an
16 out-of-network facility for UBH.
17

18 122. On October 28, 2013, Passages advised UBH case manager, Leigh McCorckle, of
19 Lauralee Pfeifer's need to "detox in a safe environment," "inability to stay sober on her own,"
20 "inadequate relapse prevention strategies," and "problems with primary support group"
21 following a fifteen-year history of alcohol abuse that included bingeing on up to two bottles of
22 hard liquor a day. UBH's case manager also noted Lauralee Pfeifer's severe withdrawal
23 symptoms, including insomnia, racing heart, vomiting, nausea, tremors, sweats, and blackouts.
24 Additionally, UBH's case manager noted, "poor sleep and appetite, racing thoughts, hopeless,
25 helpless, and worthless," and confirmed use of antidepressant and anxiolytic medications.
26
27
28

123. On October 29, 2013, UBH case manager, Clara Williams, conducted another review with Passages and noted that, apart from detoxification, **none** of Lauralee Pfeifer's presenting issues, including "high risk for relapse; poor understanding of addiction; poor ability to utilize sober supports," "problems with her husband and father when she relapsed," "externally motivated for her family some internal motivation," "inadequate relapse prevention strategies," "inadequate support," "mood issues cited in Mental Status Exam," "hopelessness," "impulsivity," and "safety plan," had been resolved. She also noted Plaintiff Pfeifer's Clinical Institute Withdrawal Assessment (CIWA-Ar) score of 8.

124. When Passages requested UBH's approval for Lauralee Pfeifer's transition from residential detoxification to residential rehabilitation, Clara Williams consulted with UBH's medical director, Dr. Jones, and advised Passages that Lauralee Pfeifer did not appear to meet the 2013 Level of Care Guidelines for SUD-Rehab, "as evidenced by passive SI" (suicidal ideation) and "completed detox."

125. Although UBH's 2013 Coverage Determination Guideline for Treatment of Substance Use Disorders expressly authorizes admission to residential rehabilitation when the CIWA-Ar score is 8 and the "the member is not at imminent risk of harm to self or others," on October 30, 2013 UBH Associate Medical Director, Malik Ahmed, formally denied Lauralee Pfeifer's residential rehabilitation admission:

United Behavioral Health (UBH) is responsible for making benefit coverage determinations for mental health and substance abuse services that are provided to United Healthcare Insurance Company members.

* * *

In the opinion of this reviewer, based on ***UBH Level of Care Guidelines*** and the information provided, this case does not meet ***Medical Necessity Criteria for Admission to Residential Rehabilitation Level of Care*** as requested. The patient has completed successful detoxification. She has mild post-withdrawal symptoms. Her vital signs are stable and she has no significant medical problems which

1 would complicate treatment. She reports depressed and anxious mood. She has
 2 passive thoughts of death, but no suicidal ideation, intention or plan. She has
 3 relationship issues related to her relapse. The patient's mood is irritable, but she
 has no psychotic symptoms.

4 The patient has external motivation from her family. She also has some internal
 5 motivation for recovery. It appears that the patient does require the structure and
 6 support of ongoing substance abuse treatment in order to help her understand her
 7 addiction, recognize triggers for relapse and build coping skills and sober
 supports. It does not, however, appear that the patient's current symptoms and
 behaviors require substance abuse residential rehabilitation level of care.

8 126. Not only did Dr. Ahmed entirely ignore UBH's own, unchanged clinical records
 9 confirming Lauralee Pfeifer's "high risk for relapse; poor understanding of addiction; poor
 10 ability to utilize sober supports," and "passive suicidal ideation" (downgraded by Dr. Ahmed to
 11 "passive thoughts of death, but no suicidal ideation"), but in basing his denial "on UBH Level of
 12 Care Guidelines" (for SUD-Rehab), Dr. Ahmed completely disregarded UBH's 2013 Coverage
 13 Determination Guideline for Treatment of Substance Use Disorders, which expressly authorizes
 14 admission when the CIWA score is 8 and the "member is not at imminent risk of harm to self or
 15 others."
 16

17 127. On November 1, 2013, following an urgent appeal by Passages, UBH Associate
 18 Medical Director, Saul Helfing, upheld UBH's denial effective October 29, 2013:

19 United Behavioral Health (UBH) is responsible for making benefit coverage
 20 determinations for mental health and substance abuse services that are provided to
 21 United Healthcare Insurance Company members.

22 * * *

23 United Behavioral Health (UBH) received a request for an expedited appeal of a
 24 non-coverage determination for residential services for the treatment of Alcohol
 25 Dependence at Passages. Your doctor has been advised that it is my determination
 26 that the non-coverage determination of benefit coverage of residential level of
 27 care will be upheld on 10/29/2013 and forward. The rationale for my decision is
 based on a review of the behavioral health services that you are receiving, a
 review of the Certificate of Coverage for Continental Offices Ltd, a review of
***UBH Level of Care Guidelines for residential treatment of Substance Related
 Disorder***, and a live telephone interview with the doctor, Dr. Sirsat Khalsa.

1 Based on the clinical information provided, you do not have any medical or
2 emotional problems that require **24-hour monitoring**. You have a supportive
3 home environment and are invested in getting help. It appears you would be able
4 to continue work on your recovery, safely and effectively, at a less restrictive
level of care, such as in an outpatient program, which is a covered benefit and is
available locally.

5 * * *

6 This is the Final Adverse Determination of your internal appeal. All internal
appeals through UBH have been exhausted.

7 128. Like Dr. Ahmed, Dr. Helfing entirely ignored Lauralee Pfeifer's high risk for
8 relapse, high-conflict social environment, and external motivation sources. Like Dr. Ahmed, Dr.
9 Helfing also completely disregarded UBH's 2013 Coverage Determination Guideline for
10 Treatment of Substance Use Disorders, which expressly authorizes admission when the CIWA
11 score is 8 and the "member is not at imminent risk of harm to self or others." Announcing a
12 new rationale in a final adverse determination without affording an advance opportunity to
13 respond, a practice expressly proscribed by Plaintiff Pfeifer's plan and ERISA, Dr. Helfing also
14 referenced "24-hour monitoring," again a function of UBH's inpatient hospitalization or
15 detoxification guidelines.
16

17 129. None of UBH's denials referenced ASAM's medical necessity criteria (or any
18 other generally accepted standards of care) or applied such criteria, despite the Illinois statutory
19 mandate.
20

21 130. As a result of UBH's self-serving policies and practices, Lauralee Pfeifer was
22 forced to incur substantial out-of-pocket costs approaching \$54,000 for her prescribed course of
23 residential treatment.
24

25 131. After Lauralee Pfeifer's discharge from Passages, she again relapsed but was
26 deterred from seeking any further residential treatment due to UBH's previous benefits denials.
27
28

1 132. On April 9, 2014, within five months of UBH's wrongful claims denials, Lauralee
2 Pfeifer died in her home from acute alcohol intoxication.

3 133. On June 26, 2014, Plaintiff Brandt Pfeifer was appointed Executor of his late
4 wife's estate.

5 **UBH'S IMPROPER DENIAL OF MUIR'S CLAIMS**

6 134. Plaintiff Brian Muir resides in Chicago, Illinois and is the beneficiary of a self-
7 funded, non-grandfathered, large group plan sponsored by Deloitte LLP, which is subject to
8 ERISA.

9 135. According to Plaintiff Muir's plan, UHIC is a "named fiduciary of the Plan for
10 purposes of denial and/or review of denied claims under the Plan. UnitedHealthcare's decision
11 on any claim will be final." Consistent with this, UHIC is the designated "Claims
12 Administrator" responsible for making benefit determinations and adjudicating appeals under
13 Plaintiff Muir's plan. For all claims and appeals, Deloitte has "delegated to the Claims
14 Administrator the exclusive right to interpret and administer the provisions of the Plan. The
15 Claims Administrator's decisions are conclusive and binding." Muir's Plan further provides that
16 UHIC "may delegate" its "discretionary authority to other persons or entities." Pursuant to this
17 authority, UHIC has delegated to UBH all discretionary authority to adjudicate mental health
18 and substance abuse-related claims.

19 136. Plaintiff Muir's plan provides for one urgent level of appeal for denied claims,
20 after which plan participants are entitled to sue. The plan expressly provides that legal action
21 "against the Claims Administrator to recover reimbursement" cannot be brought "until 90
22 calendar days after [a participant has] properly submitted a request for reimbursement as
23 described in How to File a Claim."

1 137. Additionally, Plaintiff Muir's plan expressly provides that "ERISA imposes duties
2 upon the people who are responsible for the operation of an employee benefit plan. The people
3 who operate your Plan, called 'fiduciaries' of the Plan, have a duty to do so prudently and in the
4 best interest of you and other Plan participants and beneficiaries."

5 138. Plaintiff Muir's health plan covers in- and out-of-network services that "must be
6 necessary and given for the diagnosis or treatment of an accidental injury or Sickness." It further
7 requires mental health and substance abuse services to be "consistent with generally accepted
8 standards of medical practice for the treatment of such conditions."

9 139. Among the covered services available to Plaintiff Muir under his plan is
10 residential substance abuse treatment that is consistent with generally accepted standards of
11 medical practice. The plan explicitly defines residential treatment as "intermediate care."

12 140. On March 1, 2013, at the urging of his outpatient psychiatrist and following a
13 detoxification that rendered concurrent travel for rehabilitation unsafe and a period of
14 researching the most suitable dual diagnosis rehabilitation program, Plaintiff Muir was admitted
15 to Sierra Tucson, in Tucson, Arizona, a residential treatment facility licensed by the Arizona
16 Department of Health Services and accredited by JCAHO. Sierra Tucson is an in-network
17 facility for UBH.

18 141. Plaintiff Muir's admission to Sierra Tucson was precipitated by unremitting
19 alcohol dependence over a period of nine months, co-occurring depressive and anxiety
20 disorders, suicidality, and a delayed traumatic reaction to childhood abuse. His recent relapse
21 resulted in particularly distressing symptoms and functional impairments.

22 142. On March 5, 2013, UBH case manager, Anitra Stewart, communicated with
23 Sierra Tucson and noted Plaintiff Muir's "inadequate relapse prevention strategies," "lack of
24 social support," "problems with primary support group," and food restriction and weight loss.

1 She also noted that “[member] had incident at airport where he was intoxicated they would [not]
 2 let [member] fly so he rent car and drove himself drunk pulled over and sent suicidal text, and
 3 contemplated crashing his car.” Last, Ms. Stewart noted that Plaintiff Muir was “just started on
 4 Campral for cravings” and was “resistant to 12 step model.” Thus, Ms. Stewart recognized that
 5 Plaintiff Muir was unable to abstain from alcohol use, resistant to 12-steps, lacked social
 6 support, had co-occurring mental health disorders, and was recently suicidal. Nonetheless, Ms.
 7 Stewart determined that Plaintiff Muir did not meet UBH’s “CDG-Substance use disorders,
 8 Residential rehabilitation” and forwarded Plaintiff Muir’s file for a review by UBH’s Assistant
 9 Medical Director, Jerome Kaufman.

11 143. On March 6, 2013, Dr. Kaufman reviewed Plaintiff Muir’s file and confirmed that
 12 Plaintiff Muir “reports inability to stop using on his own, impulsive while intoxicated, mood
 13 instability including panic attacks and increased depression/anxiety,” and “was being detoxed
 14 by his [outpatient] MD.” Nonetheless, in a letter dated March 7, 2013, Dr. Kaufman denied
 15 Plaintiff Muir’s residential rehabilitation in its entirety:
 16

17 United Behavioral Health (UBH) is responsible for making benefit coverage
 18 determinations for mental health and substance abuse services that are provided to
 19 UBH members.

20 * * *

21 I have determined that benefit coverage is not available from 03/01/2013 forward.
 22 The rationale for my decision to issue a noncoverage determination is based on a
 23 review of the behavioral health and substance abuse services that you are
 24 receiving, the review of the Summary Plan Description for DELOITTE, review of
 25 ***UBH Coverage Determination Guideline for Residential Rehabilitation for***
 26 ***Substance Use Disorders***, and a review of available clinical information. Services
 27 you are receiving do not appear to be consistent with generally accepted standards
 28 of practice ***based upon the applicable guideline***. Services that are not consistent
 with UBH Guidelines and with generally accepted standards of practice are not
 considered covered health services. Care could [continue] in a partial
 hospitalization program, which is a covered benefit and is available locally.

You are not in withdrawal and have demonstrated an ability to not use alcohol

1 outside of a 24 hour treatment setting.

2 144. Sierra Tucson immediately filed an urgent appeal. Without providing Sierra
3 Tucson or Plaintiff Muir an opportunity to respond to new (albeit baseless) denial rationales, a
4 practice expressly forbidden by Plaintiff Muir's plan and ERISA, on March 7, 2013 UBH's
5 Associate Medical Director Jed Goldart, M.D. issued a final (boilerplate) adverse benefit:

6
7 United Behavioral Health (UBH) is responsible for making benefit coverage
8 determinations for mental health and substance abuse services that are provided to
9 UBH members.

10 * * *

11 The rationale for my decision to issue a non-coverage determination is based on a
12 review of the behavioral health services you are receiving, review of the Deloitte
13 Summary Plan Document, review of ***United Behavioral Health (UBH) Coverage
14 Determination Guideline for Substance Disorder Residential Rehabilitation***,
15 and a live telephone interview with the doctor. Services you are receiving do not
16 appear to be consistent with generally accepted standards of practice ***based upon
17 the applicable guideline***. Services that are not consistent with United Behavioral
18 Health (UBH) Guidelines ***and with generally accepted standards of practice*** are
19 not considered covered health services.

20 * * *

21 There is no risk of withdrawal symptoms, medical or psychiatric co-occurring
22 conditions that require ***24 hour management***. There is no severe impairment in
23 the family or support system or severe, non-medical symptoms with the lack of
24 functional support systems to manage the symptoms. That evidence indicates you
25 can receive safe and effective treatment in a less intensive treatment setting such
26 as Partial Hospital Program, which was discussed with your provider.

27 * * *

28 This is the Final Adverse Determination of your internal appeal. All internal
appeals through United Behavioral Health (UBH) have been exhausted.

145. Sierra Tucson's utilization review records further reflect that UBH denied
Plaintiff Muir's claim on the basis of his not having failed treatment at a lower level of care.

146. UBH's rationales for denying Plaintiff Muir's claims, and its related internal
policies upon which those rationales were based, violate the terms of Plaintiff Muir's plan.

1 Plaintiff Muir's plan covered residential treatment for substance abuse that was consistent with
2 prevailing medical practices, yet UBH denied his claims based on its own internal practice of
3 ignoring criteria (such as lack of motivation to maintain sobriety), conflating acute
4 hospitalization and detoxification criteria (such as "withdrawal" and "24 hour management")
5 with residential treatment/rehabilitation criteria relevant to "intermediate" levels of care (such as
6 "24 hour structure"), and conditioning admission to residential rehabilitation on failing
7 treatment at lower levels of care irrespective of medical need and without heeding ASAM's
8 express warning against fail-first protocols:
9

10 Another concern that guided the development of this publication is the concept of
11 "treatment failure." This term has been used by some reimbursement or managed
12 care organizations as a prerequisite for approving admission to a more intensive
13 level of care (for example, "failure" in outpatient treatment as a prerequisite for
14 admission to inpatient treatment). In fact, the requirement that a person "fail first"
15 in outpatient treatment before inpatient treatment is approved is no more rational
16 than treating every patient in an inpatient program or using a fixed length of stay
17 for all. It also does not recognize the obvious parallels between addictive
18 disorders and other chronic diseases, such as diabetes or hypertension. For
19 example, failure of outpatient treatment is not a prerequisite for acute inpatient
20 admission for diabetic ketoacidosis or hypertensive crisis. A "treatment failure"
21 approach potentially puts the patient at risk because it delays a more appropriate
22 level of treatment, and potentially increases health care costs, if restricting the
23 appropriate level of treatment allows the addictive disorder to progress.

24 147. Ironically, on March 8, 2013, one day after Dr. Goldart issued his final adverse
25 determination, UBH case manager, Rosalyn Chambliss, updated Plaintiff Muir's case file to
26 reflect that **none** of the "critical goals to be accomplished during this level of care" had in fact
27 been resolved. According to UBH, these unfulfilled goals included addressing Plaintiff Muir's
28 "abuse/neglect," "current substance abuse," "impulsivity," "inadequate relapse prevention
strategies," "occupational/educational problems," and "social/relationship problems."

148. Having exhausted his internal remedies, on August 22, 2013 Plaintiff Muir submitted an external appeal request to UBH. Plaintiff Muir's treating psychiatrist since 2010, Dr. Aaron S. Reichlin, explained in the appeal that:

During the preceding nine months, Brian struggled with suicidal ideations (including means and plans), unremitting alcohol dependence (one-half of a fifth 3-4 times a week), and a delayed traumatic reaction to sexual abuse by a priest in adolescence. He also struggled with aggressive behavior, agitation, anxiety, blackouts, delusions, hallucinations, impaired judgment, appetite disturbance, decreased and increased need for sleep, decreased and increased sexual desire, difficulty concentrating and making decisions, being easily startled, feeling keyed up or on edge, feelings of hopelessness, obsessive-compulsive behaviors, panic attacks, social withdrawal, withdrawal symptoms, feelings of worthlessness, frequent crying, irritability, loss of interest, low energy, racing thoughts, trouble falling and staying asleep, weight decrease and increase. He also struggled with the following obsessive-compulsive behaviors: internet, computer games, rituals and habits, sexual thoughts and behaviors at work. ***Consequently, Brian suffered substantial functional impairments, including social withdrawal and inability to participate in his romantic relationship, decreased ability to perform at work, and difficulties attending to the activities of daily living (including self-care, hygiene, safety).***

Due to extensive familial history, Brian is genetically vulnerable to alcoholism and mood disorders. He began drinking alcohol at age 12 and on a daily basis in his twenties. He completed treatment in 200[5] and was sober for 5 years. He was psychiatrically hospitalized for a week in 2005 and participated in an intensive outpatient program for 2 weeks in 2007.

Regrettably, his most recent relapse resulted in particularly distressing symptoms and functional impairments that could not be safely addressed in an intensive outpatient setting (especially given the lack of social support due to his partner's demanding work travel schedule).

At my urging, Brian sought treatment at Sierra Tucson, a residential dual diagnosis program where he could pursue recovery under full-time supervision. Based on program and transportation availability, it took several days for Brian to reconstitute and safely travel from his home in Chicago to Arizona.

149. Under Plaintiff Muir's plan, UBH is permitted to contract with the external review agents of its choice and must forward "all relevant medical records" and "all other documents relied on by the Claims Administrator" to so-called "Independent Review Organizations" ("IRO"s). According to the Interim Procedures for external appeals promulgated

by the DOL (and published in Technical Release 2010-01), assigned external review agents “must provide written notice of the final external review decision within 45 days after the IRO receives the request for external review. The IRO must deliver the notice of final external review decision to the claimant and the plan.” These Interim Procedures also require UBH’s contracted IROs to “utilize legal experts where appropriate to make coverage determinations under the plan,” such as when “[a]ny applicable clinical review criteria developed and used by the plan . . . are inconsistent with the terms of the plan or with applicable law.”

150. On September 10, 2013, receipt of Plaintiff Muir’s external appeal was acknowledged in writing by the assigned IRO, MES Solutions. The IRO, however, only reported its resolution of the appeal to its client, UBH, and UBH waited until October 29, 2013 to inform Plaintiff Muir of the result (and only did so after requests from Plaintiff Muir’s attorney).

151. Since the external appeal was solely adjudicated by an unidentified psychiatrist, not only did the IRO fail to utilize legal experts to independently evaluate the expressly challenged UBH clinical review criteria, but despite acknowledging that “residential facilities provide a safe and substance-free environment in which residents learn individual and group living skills *for preventing relapse*,” the IRO continued to apply the same acute hospitalization, intoxication, and withdrawal/detox standards that UBH had promulgated and relied upon:

There is no evidence in the record that the patient, if not admitted to residential treatment, *would have continued to use alcohol* and his functioning had not deteriorated to the point he could not be safely treated in a less restrictive level of care.

* * *

While he had been at risk to harm himself, there is no evidence that the patient would have been a *high risk of harm to himself* or others due to his alcohol use at a lower level of care [given his] desire to seek treatment and his support system

1 including a partner and an outpatient psychiatrist. There had been no history of
2 suicide attempts in the past.

3 * * *

4 He clearly did not have significant risks of alcohol *withdrawal* at the time of
5 admission to the residential treatment setting as he was not placed on *detox*
6 *protocol* and Richard Watts PA-Con 03/03/2013 noted, "The patient exhibits no
7 evidence requiring detoxification."

8 152. Though it is hard to imagine how a passenger denied commercial airline boarding
9 due to intoxication who subsequently drove under the influence while texting suicide messages
10 would not be considered "a high risk of harm to himself or others," nothing short of past suicide
11 attempts would seem to have sufficed for UBH's self-selected IRO.

12 153. As a result of UBH's unlawful policies and practices, Plaintiff Muir was forced to
13 incur nearly \$30,000 of out-of-pocket costs to complete his prescribed residential treatment.

14 154. Given his conditions, it is likely Plaintiff Muir will require outpatient and
15 residential treatment for his mental health disorders in the future, and that he will submit such
16 claims to UBH pursuant to his insurance plan.

17 **UBH'S IMPROPER DENIAL OF FLANZRAICH'S CLAIMS**

18 155. Plaintiff Lori Flanzraich and her daughter, Casey, reside in South Hempstead,
19 New York. Casey Flanzraich turned 18 on June 5, 2014.

20 156. Lori and Casey Flanzraich are beneficiaries of the Oxford "Flanzraich Group
21 Health Plan" (the "Flanzraichs' Plan"). This non-grandfathered insurance plan is a fully-insured
22 group healthcare policy which is subject to ERISA.

23 157. According to the "ERISA Information" provided in the Oxford Member
24 Handbook for the Flanzraichs' Plan, "Generally, the Plan Administrator or Plan Sponsor is your
25 employer." Further, "Oxford, as the insurer, provides a Certificate of Coverage to you
26 identifying specific benefits and administrative components of your Plan."
27

1 158. The Oxford Member Handbook for the Flanzraichs' Plan further provides a
2 "Statement of ERISA Rights," enumerating "Prudent Actions By Plan Fiduciaries."

3 In addition to creating rights for Plan participants, ERISA imposes duties upon
4 the people who are responsible for the operation of the employee benefit plan.
5 The people who operate your Plan, called "fiduciaries" of the Plan, have a duty to
6 do so prudently and in the interest of you and other Plan participants and
7 beneficiaries.

8 159. Pursuant to the Certificate of Coverage ("COC") that governs the Flanzraichs'
9 Plan, benefits are paid "in accordance with the terms and conditions of this Certificate" and
10 "[Oxford] reserve[s] the right to provide the benefit in the manner [Oxford] determine[s] to be
11 medically appropriate and the most cost effective." According to the COC, "[u]nless otherwise
12 indicated in this Certificate, determinations as to Medical Necessity are made by Us, and such
13 determinations are solely within Our discretion."

14 160. The COC's attached "Information About Your Oxford Coverage" explains that
15 "[w]hen coverage is provided under Oxford's insurance company, it means Oxford Health
16 Insurance, Inc. In addition, it can also include third parties to whom we delegate responsibility
17 for providing administrative services relating to coverage, such as utilization management."
18 Pursuant to this authority, Oxford has delegated responsibility for all substance abuse-related
19 claims to UBH.

20 161. The Flanzraichs' Plan pays benefits for in- and out-of-network, residential mental
21 health and substance abuse treatment. The Plan defines "medically necessary" as "appropriate
22 with regard to standards of good medical practice" and "the most appropriate supply or level of
23 service which can safely be provided." Denied claims are subject to one internal appeal prior to
24 exhaustion of administrative remedies.

25 162. By age 16, Casey Flanzraich had been diagnosed with substance abuse, Bipolar I
26 Disorder, Oppositional Defiant Disorder, a parent-relational problem, asthma, fibromyalgia, and
27
28

1 brittle bone disease. She had been hospitalized in February and October of 2012 for alcohol
2 poisoning and suicidality. She began drinking alcohol in the seventh grade, and in 2012 she
3 began drinking more frequently (up to a bottle of vodka at once) to numb the pain in her knees.
4 Since the ninth grade, she had also smoked cannabis on a daily basis despite several
5 unsuccessful cessation attempts. During manic episodes, Casey reportedly hit her mother and
6 sister, and she reported to her providers “multiple times where she excessive[ly] drank alcohol
7 to the point where she and her family were afraid she was going to die.”
8

9 163. Due to brittle bone disease, Casey broke both feet and eventually lost the ability
10 to walk in junior high school. She had been in a wheel chair for many months in the tenth grade
11 due to fractures, hypermobility of joints, joint pain, fibromyalgia, and migraines. Because of her
12 substance abuse and mental illnesses, Casey was unable to regularly attend school during the
13 year preceding her admission to residential treatment, which was uniformly recommended by all
14 her mental health and medical providers.
15

16 164. Due to Casey’s opposition to treatment (aggravated by her substance abuse and
17 Oppositional Defiant Disorder), she quit a partial hospitalization program after just four days of
18 treatment, starting on October 16, 2012. Therefore, on December 7, 2012, Casey was admitted
19 to New Haven Residential Treatment Center (“New Haven”) in Spanish Fork, Utah.
20

21 165. New Haven is licensed as a residential treatment facility by the Utah Department
22 of Human Services and is accredited by JCAHO, which has also awarded it the “Gold Seal of
23 Approval.” New Haven is an out-of-network provider with UBH.

24 166. Psychological testing by New Haven revealed that Casey “evinces a maladaptive
25 pattern of alcohol and/or drug abuse that has led to significant impairment of her performance
26 and behavior.” The testing also indicated that “[s]he may spend an inordinate amount of time
27 obtaining these substances, behave in a socially unacceptable manner, and has continued to use
28

1 alcohol and/or drugs even though she knows they have persistent and deleterious effects on her
 2 life.” Furthermore, New Haven’s analysis reported as follows: “[R]esults of Casey’s profile
 3 indicate that there is a high probability that she has had a substance dependence disorder. The
 4 results also indicate that she may be part of a family and social system that promotes rather than
 5 prevents substance misuse. Therefore, she may view her problems associated with substance
 6 misuse as trivial or inevitable.”

8 167. Despite the overwhelming evidence indicating that Casey needed residential care,
 9 UBH Associate Medical Director Satwant Ahluwalia, M.D., nevertheless denied Casey’s
 10 residential coverage from the date of her admission in a retrospective February 18, 2013 Initial
 11 Adverse Determination:

12 United Behavioral Health (UBH) is responsible for making benefit coverage
 13 determinations for mental health and substance abuse services that are provided to
 14 Oxford Health Insurance, Inc NY-PPO members.

15 * * *

16 As requested, I have completed a review of your medical record for the dates of
 17 service 12/7/12-forward. Based on my review, I have determined that coverage
 18 for the requested services was not available for the following reasons:

19 Based on the clinical information and ***UBH Level of Care Guidelines for Mental***
 20 ***Health Residential Care***, effective treatment could have occur[r]ed in a less
 21 restrictive partial hospital program. There is no current clinical information
 22 showing the medical necessity for this level of care. There was no evidence of
 23 severe psychosocial dysfunction, severe behavioral problems or serious medical
 24 conditions requiring ***24-hour care***. There was no evidence that the member would
 25 otherwise need ***acute inpatient care***.

26 168. Although Dr. Ahluwalia was fully aware of Casey’s substance abuse, severe
 27 medical comorbidities, prior outpatient treatment failures, and familial psychopathology
 28 undermining recovery, her superficial and acute-focused review of Casey’s claims failed to
 account for Casey’s dual (mental health and substance use disorder) diagnoses, relying
 exclusively on the UBH Level of Care Guidelines for Mental Health Residential Care

1 169. Consequently, when Plaintiff Flanzraich filed an appeal with UBH on August 2,
 2 2013, she specifically noted that Dr. Ahluwalia “was not properly assessing Casey’s dual
 3 diagnosis” and that Dr. Ahluwalia had failed to consider Casey’s care under the UBH Level of
 4 Care Guidelines for Substance Use Disorders: Residential Rehabilitation.

5 170. To her appeal, Plaintiff Flanzraich attached an October 12, 2012 report prepared
 6 by Casey’s physician, Matthew S. Cohen, M.D., F.A.A.P.:
 7

8 Casey Flanzraich is a 16 year old female with a medical history including
 9 Asthma, chronic Sinusitis, Osteopetrosis, Conversion disorder, Anxiety disorder,
 10 Constipation, Hypercholesterolemia and Hyperlipidemia. She suffers from severe
 11 persistent Asthma as well as multiple sinus infections resulting in surgeries to
 12 remove both tonsils and adenoids, and repair a deviated septum. Possibly
 13 secondary to corticosteroid usage used to treat her Asthma, Casey developed
 14 Osteopenia. She has spent significant time immobilized, including the previous
 15 use of a wheelchair. This resulted in multiple lengthy absences from school. Last
 16 year, Casey was unable to walk intermittently for a period of ten months, and she
 17 was home schooled. At this time, she started suffering numerous significant panic
 18 attacks. Casey also exhibits hypermobility. It is postulated that her illnesses may
 be a result of a genetic autoimmune disorder. Casey has been diagnosed Bipolar
 and has had several manic episodes and numerous bouts of depression. This has
 led to excessive alcohol use and thoughts of suicide. At this time, she is presently
 undergoing psychiatric care at Long Island Jewish Medical Center. As her doctor,
 I feel it would be beneficial for Casey to be in a therapeutic school setting. Casey
 has been out of school for approximately two weeks prior to her hospitalization.
 She is incapable of attending school on a regular basis due to her illness.

19 171. With her appeal, Plaintiff Flanzraich also provided evidence that intensive
 20 outpatient treatment did could not support Casey’s recovery, as confirmed on March 15, 2013
 21 by Casey’s psychologist, Bradford E. Jacobs, Ph.D.:

22 Casey Flanzraich was seen for assessment and treatment beginning on September
 23 27, 2012 through November 15, 2012, with the exception of two weeks when she
 24 was hospitalized due to excessive alcohol consumption and subsequent suicidal
 ideation.

25 * * *

26 *It became clear that Casey was not a good candidate for outpatient*
 27 *psychotherapy and would require inpatient care and treatment, despite*
 28 *aggressive medication management and frequent individual and family*

psychotherapy sessions. Casey was deteriorating mentally and emotionally. She was unmotivated and did not want to get out of bed most mornings. Frequent thoughts of death and dying were evident. *It became urgent that Casey be transferred to a residential treatment facility that could adequately address these very severe issues. Treatment was terminated on November 15, 2012 so that Casey could pursue appropriate treatment in a full time residential facility.*

(Emphasis added.)

172. Additionally, Plaintiff Flanzraich included with her appeal a March 19, 2013 report from Casey's outpatient psychiatrist, Stanley M. Hertz, M.D.:

Casey Flanzrich has been under my care for treatment of a bipolar mood disorder complicated by alcohol and substance abuse. In addition, there was school refusal. Placement at a residential school was medically necessary to prevent continued substance abuse and insure attendance at school. Intensive psychotherapy with psychiatric management on an outpatient basis did not curtail dangerous behaviors. It was only under twenty four hour supervision that Casey has controlled these dysfunctional behaviors and attended school on a regular basis.

173. Despite Plaintiff Flanzraich's clear and well-articulated arguments and supporting evidence, on August 23, 2013 UBH Associate Medical Director, Danesh Alam, M.D., denied the appeal:

United Behavioral Health (UBH) is responsible for making benefit coverage determinations for mental health and substance abuse services provided to Oxford Health Insurance, Inc. NY /PPO members.

* * *

I have determined that benefit coverage is not available for the following reason(s):

It is my determination to uphold the previous denial of this request for mental health residential treatment center benefit coverage for lack of medical necessity. The rationale for this determination is based on the clinical information and the UBH Level of Care Guidelines for Mental Health Residential care. It appeared that your child's treatment could have occurred in a less restrictive mental health partial hospitalization program. There was no evidence showing the medical necessity for a 24-hour level of care such as lack of social supports, or medical or psychiatric conditions requiring 24-hour care. There was no evidence that inpatient treatment would be needed if not for the residential care. Therefore the previous denial is upheld.

* * *

1 This is the Final Determination of your internal Appeal. All internal appeals
2 through UBH have been exhausted.

3 174. Basing the clinically uncorroborated denial exclusively on the UBH Level of Care
4 Guidelines for Mental Health Residential Care, not only did Dr. Alam deprive the claimants of a
5 “full and fair review” under ERISA by ignoring applicable substance abuse criteria for a patient
6 with dual diagnoses, but she also covertly denied the appeal based on a proscribed rationale
7 noted in her case management records and conspicuously omitted from the denial letter: ***“There***
8 ***was no evidence of an imminent risk of harm to self or others.”***

9
10 175. Thus, not only did UBH continue to improperly apply acute hospitalization
11 criteria (such as “imminent risk of harm to self or others”) to sub-acute residential mental health
12 treatment, but UBH also repeatedly ignored the Flanzraich Plan’s definition of medical
13 necessity and persistently failed to apply “standards of good medical practice” such as those
14 promulgated by ASAM or AACAP – or to consider even its deficient CDGs or LOC Guidelines
15 for substance use disorders for an adolescent patient with a dual diagnoses.
16

17 176. Like Plaintiff Muir, Plaintiff Flanzraich submitted a request for an external review
18 by an IRO. According to the assigned IRO, “MCMC has over 300 corporate clients, including
19 some of the nation’s largest health insurers and managed care organizations.” UBH is one of
20 MCMC’s numerous corporate clients. While MCMC is also assigned external appeals by some
21 state insurance departments to review fully-insured cases (like Plaintiff Flanzraich’s), such
22 external appeals are nonetheless directly paid for by UBH. More importantly, MCMC’s
23 reviewers are ever mindful that their determinations in fully-insured cases directly affect
24 insurers’ bottom lines and that costly findings in favor of fully-insured claimants can impact
25 lucrative contracts in self-funded cases entirely controlled by UBH. (For this reason, some states
26
27
28

1 like California do not permit MCMC and other external review agents that directly contract with
2 insurers in self-funded ERISA cases to adjudicate fully-insured appeals.)

3 177. While the IRO acknowledged Casey Flanzraich's diagnoses of alcohol abuse,
4 cannabis abuse, and oppositional defiant disorder (among others), that her residential treatment
5 at New Haven "gradually addressed *core issues driving her acting out and addictive*
6 *behaviors*," that "there was obvious parental conflict throughout treatment" undermining
7 Casey's recovery, and that having recently "attended the PHP (partial hospitalization program)
8 for only four days, the patient refused to return," MCMC, like MES Solutions, applied UBH's
9 acute-focused guidelines to uphold UBH's denial:
10

11 The patient was not *acutely* out of control in a way that required 24-hour daily
12 structure and supervision. She had *chronic behavioral and mood problems*
13 *clearly related to a dysfunctional family*. There was no evidence of appropriately
14 intensive outpatient therapy with a strong family component. Therefore, there was
15 no evidence that this patient required such a restrictive level of care and would not
16 have responded equally well to intensified outpatient treatment for her and her
17 parents.

18 178. This decision was erroneous for many of the reasons that UBH's initial denial was
19 improper. First, like UBH, the IRO failed to properly classify residential treatment as an
20 intermediate level of care not limited to the treatment of "acute" conditions. Second, like UBH,
21 the IRO failed to evaluate Casey's level of care pursuant to *any* clinical criteria for substance
22 abuse and instead referenced AACAP's Practice Parameter for the Assessment and Treatment of
23 Children and Adolescents With *Depressive Disorders* along with an article from a journal of
24 *hospital* medicine and a generic psychiatry textbook, from which nothing was quoted.
25 Ironically, had the IRO even faithfully applied its referenced AACAP Practice Parameter for
26 Depressive Disorders, it would have noted that "chronicity" and "family conflict" are expressly
27 enumerated factors weighing in favor of residential treatment due to concerns with the course of
28 the disease, since AACAP's Practice Parameter for Depressive Disorder states: "In general,

1 greater severity, *chronicity*, or multiple recurrent episodes, *comorbidity*, hopelessness, presence
2 of residual subsyndromal symptoms, negative cognitive style, *family problems*, low
3 socioeconomic status, and *exposure to ongoing negative events* (abuse, *family conflict*) are
4 associated with poor outcome (Birmaher et al., 2002; Lewinsohn et al., 1998).”

5 179. In fact, AACAP’s Principles of Care for Treatment of Children and Adolescents
6 with Mental Illnesses in Residential Treatment Centers explicitly advise that “[t]he best
7 intervention for serious mental health issues that cannot be treated in the child’s home
8 environment is a facility that has a multidisciplinary treatment team providing safe, evidence
9 based care that is medically monitored . . . Residential treatment might be indicated to treat
10 adolescents with substance abuse disorders when the *chronic nature of their problems* has
11 failed to respond to intensive outpatient or partial hospitalization programs.” Given that Casey
12 refused to attend a partial hospitalization program for more than 4 days prior to her admission to
13 New Haven (in no small part due to her comorbid diagnosis of oppositional defiant disorder)
14 and that her outpatient mental health providers terminated her care so that she would receive
15 residential treatment, coupled with Casey’s severely dysfunctional family environment (marred
16 by divorce and her father’s mental illness), it is difficult to imagine how Casey could not have
17 met AACAP’s standard had it been faithfully applied by the IRO.
18
19

20 180. As a result of UBH’s persistent and willful violations of ERISA, Plaintiff
21 Flanzraich incurred nearly \$90,000 of out-of-pocket expenses to cover the prescribed course of
22 Casey’s residential treatment through July 15, 2013.
23

24 181. Given her conditions, it is likely Casey Flanzraich will require outpatient and
25 residential treatment for her mental health disorders in the future, and that she will submit such
26 claims to UBH pursuant to her insurance plan.
27
28

182. Plaintiff Flanzraich brings this action in the capacity of her daughter's Agent pursuant to a Power of Attorney executed by Casey Flanzraich following her eighteenth birthday.

CLASS ACTION ALLEGATIONS

183. Plaintiffs incorporate by reference the preceding paragraphs as though such paragraphs were fully stated herein.

184. UBH serves as the claims administrator for mental health and substance abuse treatment claims for other health insurance plans that define covered residential treatment in the same way as the Wit, Muir, Pfeifer and Holdnak plans (i.e. treatment that is consistent with generally accepted guidelines and UBH's LOCs). The policies and practices that UBH followed with respect to the claim filed by Plaintiffs Wit, Muir, Pfeifer and Holdnak are the same as those that have been applied by UBH to other similarly situated insureds seeking mental health and substance abuse treatment benefits under their health plans.

185. UBH serves as the claims administrator for mental health and substance abuse treatment claims for other health insurance plans that define covered residential treatment in the same way as the Flanzraich plan (i.e. treatment that is consistent with standards of good medical practice). The policies and practices that UBH followed with respect to the claim filed by Plaintiff Flanzraich are the same as those that have been applied by UBH to other similarly situated insureds seeking mental health and substance abuse treatment benefits under their health plans.

186. As such, pursuant Federal Rule of Civil Procedure 23, Plaintiffs bring their claims on behalf of a putative class of similarly situated individuals as noted in the counts below. The class (the "Class") is defined as follows:

All participants or beneficiaries in an insurance plan governed by ERISA, for

1 which UBH has been delegated the authority to make coverage decisions with
 2 respect to claims for mental health and substance abuse-related treatment, who
 3 sought and were denied coverage for all or a portion of residential treatment for
 4 mental health or substance use, within the applicable statute of limitations.

5 187. The members of the Class can be objectively ascertained through the use of
 6 information contained in UBH's files because UBH knows who its insureds are, which plans
 7 they are insured by, what type of claims they have filed, and how those claims were adjudicated.

8 188. There are so many persons within the putative classes that joinder is
 9 impracticable.

10 189. Certification of the Class is desirable and proper because there are questions of
 11 law and fact in this case that are common to all members of each of the class. Such common
 12 questions of law and fact include, but are not limited to, the following:

- 13 A. What legal duties does ERISA impose upon UBH when it serves as a claims
 14 administrator for mental health and substance abuse claims;
- 15 B. Does UBH engage in a fiduciary act when it promulgates mental health and
 16 substance use level of care and coverage determination guidelines;
- 17 C. Are UBH's level of care and coverage determination guidelines consistent
 18 with those that are generally accepted in the medical community;
- 19 D. Does UBH's promulgation of these policies constitute a breach of fiduciary
 20 duty;
- 21 E. Does UBH engage in a fiduciary act when it adjudicates a claim for benefits;
- 22 F. Does UBH have a practice of applying guidelines related to inpatient
 23 hospitalization or detoxification to claims for residential treatment;
- 24 G. Does UBH's systemic misapplication of inpatient hospitalization criteria to
 25 claims for residential treatment constitute a breach of fiduciary duty;
- 26
- 27
- 28

1 H. What remedies are available if UBH is found liable for the claims alleged;

2 190. Certification is desirable and proper because Plaintiffs' claims are typical of the
3 claims of the members of the classes Plaintiffs seek to represent.

4 191. Certification is also desirable and proper because Plaintiffs will fairly and
5 adequately protect the interests of the classes they seek to represent. There are no conflicts
6 between the interests of Plaintiffs and those of other members of the classes, and Plaintiffs are
7 cognizant of their duties and responsibilities to the entire class. Plaintiffs' attorneys are
8 qualified, experienced and able to conduct the proposed class action litigation.
9

10 192. It is desirable to concentrate the litigation of these claims in this forum. The
11 determination of the claims of all class members in a single forum, and in a single proceeding
12 would be a fair and efficient means of resolving the issues in this litigation.
13

14 193. The difficulties likely to be encountered in the management of a class action in
15 this litigation are reasonably manageable, especially when weighed against the virtual
16 impossibility of affording adequate relief to the members of the class through numerous separate
17 actions.

18 **COUNT I**

19 **CLAIM FOR VIOLATION OF FIDUCIARY OBLIGATIONS**
20 **BROUGHT ON BEHALF OF PLAINTIFFS AND THE CLASS**

21 194. Plaintiffs incorporate by reference the preceding paragraphs as though such
22 paragraphs were fully stated herein.

23 195. This count is brought pursuant to 29 U.S.C. § 1132(a)(1)(B).

24 196. As the entity responsible for making mental health and substance abuse benefit
25 determinations under Plaintiffs' Plans, and responsible for developing internal practices and
26 policies to facilitate such determinations, UBH is an ERISA fiduciary.
27

1 197. As an ERISA fiduciary, and pursuant to 29 U.S.C. Section 1104(a), UBH is
2 required to discharge its duties “solely in the interests of the participants and beneficiaries” and
3 for the “exclusive purpose” of providing benefits to participants and their beneficiaries” and
4 paying reasonable expenses of administering the plan. It must do so with reasonable “care, skill,
5 prudence, and diligence” and in accordance with the terms of the plans it administers. It must
6 conform its conduct to a fiduciary duty of loyalty and may not make misrepresentations to its
7 insureds.
8

9 198. UBH violated these duties by promulgating the restrictive level of care and
10 coverage determination guidelines discussed herein. Despite the fact that the health insurance
11 plans that insure Plaintiffs and the Class provide for insurance coverage for residential
12 treatment, the fact that generally accepted standards of care are widely available and well-
13 known to UBH, and that fact that UBH asserted that its guidelines were consistent with those
14 that are generally accepted, UBH developed guidelines that are far more restrictive than those
15 that are generally accepted. In doing so, UBH did not act “solely in the interests of the
16 participants and beneficiaries” for the “exclusive purpose” of “providing benefits.” It did not
17 utilize the “care, skill, prudence, and diligence” of a “prudent man” acting in a similar capacity.
18 It did not act in accordance with the terms of Plaintiffs’ Plans.
19

20 199. Instead, UBH elevated its own interests and those of its corporate affiliates above
21 the interests of plan participants and beneficiaries. By promulgating improperly restrictive
22 guidelines, UBH artificially decreased the number and value of covered claims thereby
23 benefiting its corporate affiliates at the expense of insureds.
24

25 200. UBH’s breach of fiduciary duties is underscored by the fact that it also ignored
26 state laws requiring it to apply ASAM standards when making medical necessity
27 determinations.
28

201. Plaintiffs and the members of the Class have been harmed by UBH's breaches of fiduciary duty because their claims have been subjected to UBH's restrictive guidelines making it less likely that UBH will determine that their claims are covered.

202. Plaintiffs and the members of the Class seek the relief identified below to remedy this claim.

COUNT II

CLAIM FOR IMPROPER DENIAL OF BENEFITS BROUGHT ON BEHALF OF PLAINTIFFS AND THE CLASS

203. Plaintiffs incorporate by reference the preceding paragraphs as though such paragraphs were fully stated herein.

204. This count is brought pursuant to 29 U.S.C. §1132(a)(1)(B).

205. UBH denied the insurance claims for residential treatment submitted by Plaintiffs and other members the Class in violation of the terms of Plaintiffs' Plans and the insurance plans that insure members of the Class. UBH denied these claims, in part, based on its restrictive internal guidelines that were developed in violation of its fiduciary duties. It also denied these claims, in part, based on its systematic practice of: (i) improperly applying acute inpatient treatment criteria to residential treatment claims; (ii) ignoring the evidence presented to it; (iii) applying undisclosed additional criteria to benefit claims, such as a length of stay "benchmark"; and (iv) relying upon its restrictive CDGs even though CDGs (as opposed to LOCs) are not a recognized basis for denying claims under Plaintiffs' Plans.

206. Plaintiffs and the members of the Class have been harmed by Defendants' improper benefit denials because they were deprived of insurance benefits they were owed.

207. Plaintiffs and the members of the Class seek the relief identified below to remedy this claim.

COUNT III

**CLAIM FOR EQUITABLE RELIEF
BROUGHT ON BEHALF OF PLAINTIFFS AND THE CLASS**

208. Plaintiffs incorporate by reference the preceding paragraphs as though such paragraphs were fully stated herein.

209. This count is brought pursuant to 29 U.S.C. § 1132(a)(3)(A) only to the extent that the Court finds that the injunctive relief sought to remedy Counts I and/or II are unavailable pursuant to 29 U.S.C. § 1132(a)(1)(B).

210. Plaintiffs and the Class have been harmed, and are likely to be harmed in the future, by UBH's breaches of fiduciary duty described above.

211. In order to remedy these harms, Plaintiffs and the Class are entitled to enjoin these acts and practices pursuant to 29 U.S.C. § 1132(a)(3)(A).

COUNT IV

**CLAIM FOR OTHER APPROPRIATE EQUITABLE RELIEF
BROUGHT ON BEHALF OF PLAINTIFFS AND THE CLASS**

212. Plaintiffs incorporate by reference the preceding paragraphs as though such paragraphs were fully stated herein.

213. This count is brought pursuant to 29 U.S.C. § 1132(a)(3)(B) only to the extent that the Court finds that the equitable relief sought to remedy Counts I and II are unavailable pursuant to 29 U.S.C. § 1132(a)(1)(B).

214. Plaintiffs and the Class have been harmed, and are likely to be harmed in the future, by UBH's breaches of fiduciary duty described above.

215. Additionally, by engaging in this misconduct, UBH allowed its corporate affiliates to be unjustly enriched insofar as they were not required to pay benefit claims.

216. In order to remedy these harms, Plaintiffs and the Class are entitled to appropriate equitable relief pursuant to 29 U.S.C. § 1132(a)(3)(B).

REQUESTED RELIEF

WHEREFORE, Plaintiffs demand judgment in their favor against Defendants as follows:

A. Certifying the Class and their claims, as set forth in this Complaint, for class treatment;

B. Appointing the Plaintiffs as Class Representatives for the Class;

C. Designating Zuckerman Spaeder LLP and Psych-Appeal, Inc. as counsel for the Class;

D. To remedy Count I, or alternatively pursuant to Count III, declaring that UBH's internal guidelines complained of herein were developed in violation of UBH's fiduciary duties;

E. To remedy Count I, or alternatively pursuant to Count III, issuing a permanent injunction ordering UBH to stop utilizing the guidelines complained of herein, and instead adopt or develop guidelines that are consistent with those that are generally accepted and with the requirements of applicable state law;

F. To remedy Count II, or alternatively pursuant to Count III, declaring that UBH's denials of residential treatment coverage were improper;

G. To remedy Count II, or alternatively pursuant to Count III, ordering UBH to reprocess claims for residential treatment that it previously denied (in whole or in part) pursuant to new guidelines that are consistent with those that are generally accepted and with the requirements of applicable state law;

H. To remedy Count II, or alternatively pursuant to Count III, ordering UBH to faithfully apply its promulgated guidelines (including any new guidelines UBH may adopt or promulgate in response to the relief sought herein) in reprocessing claims for residential

1 treatment that it previously denied (in whole or in part), and in processing future claims for
2 residential treatment;

3 I. To remedy Counts I and/or II, or alternatively pursuant to Count IV, ordering
4 UBH to pay a surcharge to Plaintiffs and members of the Class in an amount equivalent to the
5 revenue it generated from its corporate affiliates or the plans for providing mental health and
6 substance abuse-related claims administration services with respect to claims filed by Plaintiffs
7 and members of the Class, expenses that UBH's corporate affiliates saved due to UBH's
8 wrongful denials, the out-of-pocket costs for residential treatment that Plaintiffs and members of
9 the Class incurred following UBH's wrongful denials, and/or pre-judgment interest;

11 J. Awarding Plaintiffs' disbursements and expenses for this action, including
12 reasonable counsel fees, in amounts to be determined by the Court, pursuant to 29 U.S.C. §
13 1132(g); and
14

15 K. Granting such other and further relief as is just and proper.

16 Dated: August 18, 2014

17 Respectfully submitted,

19 /s/ Meiram Bendat

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